85-810

No.

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM 1985

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND FOOD EMPLOYERS HEALTH AND WELFARE FUND, and the BOARD OF TRUSTEES thereof; and MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS DRUG AND MERCANTILE EMPLOYEES WELFARE FUND, and the BOARD OF TRUSTEES thereof,

Petitioners

v.

NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN; JEAN CARLSON and THOMAS PIERSON, DEPUTY COMMISSIONERS OF INSURANCE OF THE STATE OF MICHIGAN; and THE BUREAU OF INSURANCE OF THE STATE OF MICHIGAN,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND APPENDIX

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QUESTION PRESENTED

WHETHER UNINSURED EMPLOYEE WELFARE BENEFIT PLANS, WHICH ARE IMMUNE FROM STATE INSURANCE REGULATION UNDER ERISA (*METROPOLITAN LIFE INSURANCE CO.* v. *COMMONWEALTH OF MASSACHUSETTS*, 471 U.S. ——, 105 S. CT. 2380 (1985)), LOSE THEIR IMMUNITY WHEN THEY ACQUIRE CATASTROPHIC BENEFIT LOSS COVERAGE.

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v.

NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN; JEAN CARLSON and THOMAS PIERSON, DEPUTY COMMISSIONERS OF INSURANCE OF THE STATE OF MICHIGAN; and THE BUREAU OF INSURANCE OF THE STATE OF MICHIGAN,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund, and its Board of Trustees, and the Michigan United Food and Commercial Workers Unions Drug and Mercantile Employees Welfare Fund, and its Board of Trustees,[1] by counsel, respectfully pray that the Court grant the Petition for Writ of Certiorari.

[1]Hereafter referred to as "The Funds". Respondents Nancy A. Baerwaldt, Commissioner of Insurance of the State of Michigan, and Jean Carlson and Thomas Pierson, Deputy Commissioners of Insurance of the State of Michigan, and the Bureau of Insurance of the State of Michigan, are hereafter referred to as "the Commissioner."

OPINIONS BELOW

The opinion of the Sixth Circuit Court of Appeals (App., *infra*, pp. 1a-7a), is reported at 767 F.2d 308 (CA 6 1985).[2] The opinion of the District Court for the Eastern District of Michigan (App., *infra*, pp. 8a-19a) is reported at 572 F. Supp. 943 (E.D. Mi. 1983).

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit was made and entered on July 19, 1985, and a copy thereof is appended to this petition (App., *infra*, p. 20a). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTES INVOLVED

The pertinent provisions of 1980 PA 429, amending the Michigan Insurance Code, Michigan Comp. Laws Ann. (M.C.L.A.) §§ 500.3425, .3609a; and of Section 514 of ERISA, 29 U.S.C. 1144, are set forth in the Appendix, *infra*, pp. 21a-23a.

STATEMENT OF THE CASE

In 1980, the Michigan Legislature enacted 1980 Michigan Public Act No. 429, Michigan Comp. Laws Ann. (M.C.L.A.) §§ 500.3425, .3609a (1983), amending the state Insurance Code (App., *infra*, pp. 21a-22a). Act 429 requires every insurer offering health insurance policies in Michigan to provide specified levels of coverage for substance abuse.

Plaintiffs are employee benefit trust funds established under Sec. 302(c) of the Labor Management Relations Act of 1947, as amended, 29 U.S.C. 186(c), to provide health and welfare benefits to covered employees of contributing employers in the supermarket and in the drug and mercantile industries in Michigan. The Funds are "employee benefit plans" as defined

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[2]The parties to the proceedings below in the Sixth Circuit Court of Appeals are as set forth in the caption of this case, *supra*.

in Sec. 3(3) of ERISA, 29 U.S.C. 1002(3), and "employee welfare benefit plans" as defined in Sec. 3(1) of ERISA, 29 U.S.C. 1002(1).

The plaintiff Boards of Trustees of each Fund have entered into "Flexible Funding Plan Agreements" with the Transamerica Occidental Life Insurance Company. Under this arrangement, the Funds are "self-insured" (i.e., self-funded) up to a trigger point, called the "claims liability limit," which is a specified annual aggregate dollar amount of claims beyond which the carrier covers excess or catastrophic loss.[3] The "claims liability limit" has never been reached during the history of these agreements. The Funds adjudicate claims and payments are made from accounts in the Funds' names; the carrier provides administrative support services, actuarial accounting, and preparation of plan description booklets, which, *inter alia*, inform participants that the Funds are not insured below the "claims liability limit."

The Funds provide benefits for alcoholism and drug abuse treatment, but not to the extent mandated by 1980 PA 429. On October 12, 1982, plaintiffs filed a complaint[4] in the United States District Court, Eastern District of Michigan, naming as defendant Nancy A. Baerwaldt, the Insurance Commissioner of the State of Michigan. The complaint alleged that 1980 PA 429 was preempted by ERISA as applied to the Funds, and sought declaratory and injunctive relief prohibiting the Insurance Commissioner from applying the requirements of 1980 PA 429 to the Funds' agreements with Transamerica Occidental. Jurisdiction of the District Court was based on 28 U.S.C. 1331(a) and 1337, and ERISA Sec. 502(a)(3) and (f), 29 U.S.C. 1132(a)(3) and (f).

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[3]There is a "claims liability limit" applicable to individual claims, beyond which there is similar catastrophic loss coverage.

[4]An amended complaint filed on April 13, 1983, added the Boards of Trustees of the Funds as plaintiffs.

The defendant moved to dismiss, and plaintiff Funds moved for summary judgment pursuant to Fed. R. Civ. P. Rule 56. The Hon. John Feikens, Chief District Judge, issued an opinion on June 16, 1983, denying the motion to dismiss and granting summary judgment for the plaintiffs (App., *infra*, pp. 8a-19a). The court held 1980 PA 429 preempted by ERISA as an impermissible indirect regulation of the terms of an employee benefit plan.

Defendant appealed to the Sixth Circuit Court of Appeals. On June 3, 1985, after briefs and oral arguments had been submitted to the Court of Appeals, this Court issued its decision in *Metropolitan Life Insurance Co.* v. *Commonwealth of Massachusetts*, 471 U.S. —, 105 S.Ct. 2380 (1985). On July 19, 1985, without further briefing or argument, the Sixth Circuit Court of Appeals issued its opinion, reversing the District Court and remanding for further proceedings (App., *infra*, pp. 1a-7a). The Sixth Circuit held that 1980 PA 429 is not preempted by ERISA. The Court stated first that the holding of *Metropolitan Life, supra*, is controlling, since that case "presented precisely the issue that confronts us in the case at bar and upheld the challenged statute." (App., *infra*, p. 5a). Next, the Court acknowledged that the "stop-loss" nature of the Funds' insurance policies presented an additional question, but a question the court could summarily decide: "The 'stop-loss' nature of the plans does not alter our conclusion. . . . As long as the plans purchase insurance from 'an insurer offering health insurance policies in' Michigan, the policies must include the substance abuse coverage specified by Act 429." (App., *infra*, pp. 5a-6a).[5]

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[5]The Sixth Circuit also held 1980 PA 429 not preempted by the National Labor Relations Act, citing *Metropolitan Life, supra*. The District Court had added NLRA preemption of the Michigan law as an alternative basis for summary judgment (App., *infra*, pp. 18a-19a).

REASONS FOR GRANTING THE PETITION

Six weeks after this Court clarified complex and important issues of ERISA preemption in *Metropolitan Life Insurance Co.* v. *Massachusetts, supra*, the Sixth Circuit issued a decision which muddies the waters so recently calmed by this Court. Holding Michigan Public Act 429 applicable to self-funded and essentially self-insured employee welfare plans, by virtue of the plans' "excess loss" insurance coverage, the Court of Appeals has distorted the differentiation between "uninsured" — and therefore ERISA preempted — and "insured" — and therefore not preempted — plans elucidated in *Metropolitan Life, supra*[6] — with the impermissible result that ERISA's "insurance savings" exception swallows the rule of broad ERISA preemption. "ERISA's authors clearly meant to preclude the states from avoiding through form the substance of the preemption provision." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

The court below has decided a most important federal question in a manner that conflicts with the teaching of *Metropolitan Life, supra*, and departs from the consistent interpretation of ERISA Section 514 as mandating broad federal preemption subject to narrow enumerated exceptions. *See, Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85, (1983).

The impact of the Sixth Circuit's misapplication of *Metropolitan Life* will be extensive. The involvement of insurance providers in the funding and administration of employee welfare benefit plans covers a broad spectrum from provision of "administrative services only" ("ASO"), to various combined insured-uninsured arrangements ("excess loss" coverage, "min-

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[6] "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter."
Metropolitan Life, supra, 471 U.S. at __ , 105 S. Ct. at 2393.

imum premium" plans), to full conventional insurance. *See,* Arnett & Trapnell, *Private Health Insurance: New Measures of a Complex and Changing Industry,* 6 Health Care Financing Review 31 (1984). A growing number of self-funded and primarily self-insured employee welfare benefit plans, such as the plaintiff UFCW Funds, purchase "excess risk," "stop-loss," or "minimum premium" insurance coverage (60.9% of the sample in one recent survey of single employer plans). Geisel, *Surveys Find Most Employers Self-funding Health Benefits,* 19 Business Insurance, 3, 10-11 (Jan. 1, 1985). These arrangements allow the plans to self-insure, while enabling fiduciaries to protect assets from catastrophic depletion. Fossett, *Self-Insurance Group Plans Examined,* National Underwriter: Life and Health Insurance, May 1, 1982, at 18-19; Cain, *Large, Small Self-Insurers' Techniques Differ,* 17 *Business Insurance* 11 (Jan. 31, 1983).

Under the Sixth Circuit's simplistic analysis, these plans in their various configurations are indiscriminately affected by state regulation of terms and benefit levels solely by virtue of insurance policies underwriting marginal risks. In fact, under that analysis, only approximately *eighteen percent* of the employee health care market — those totally self-insured plans without any purchased insurance coverage — will be subject to the exclusive federal regulation of terms and benefits mandated by Sec. 514(a) of ERISA! *See,* Arnett & Trapnell, *supra,* at pp. 34-35.[7]

The Funds submit, for the reasons stated below, that the Court of Appeals has misconstrued the instruction of *Metropolitan Life,* to reach a result that is discordant with ERISA and with applicable legal precedent. It is a result that will, if allowed to stand uncorrected, fundamentally undermine the

[7] "Some companies assume all the risk and totally self-fund their health care coverages without stop-loss insurance but this number is believed to be small." Geisel, *supra,* at p. 11.

Concededly, the Sixth Circuit's ruling would not affect self-funded plans which *reinsure* any of their risks (with or without administrative services by an insurance carrier).

supremacy of federal regulation of employee welfare benefit plans — the "crowning achievement" of ERISA. Remarks of Rep. Dent, 120 Cong, Rec. 29197 (Aug. 20, 1974) quoted at *Shaw* v. *Delta Air Lines, Inc., supra,* 463 U.S. at 99.

I

THE OPINION BELOW IS AMBIGUOUS, UNWORKABLE AND IN CONFLICT WITH APPLICABLE PRECEDENT.

The Funds, through their "Flexible Funding" arrangement with Transamerica Occidental Life Insurance Company, are in fact primarily uninsured, and only marginally insured. Up to an aggregate amount dollar amount of claims (the "claims liability limit"), the Funds are self-insured; they administer and adjudicate claims, they bear the liability for payment, and claimants or providers are paid directly from a separate account of the Funds. When aggregate claims exceed the "claims liability limit" (a contingency which has never occurred), the Funds are no longer self-insured; Transamerica then assumes liability and payments are made to claimants and providers from Transamerica's accounts.

The Funds' contract with Transamerica is one of many varieties of "excess loss" or "minimum premium" coverage purchased by self-funded employee welfare benefit plans. The Sixth Circuit erroneously sidesteps a complex issue by indiscriminately characterizing the Funds as "insured," *despite* the fact that they are essentially *self-funded* or *self-insured*, with a separable insured component.

The Sixth Circuit's conclusion that the mere existence of an "excess loss" insurance contract transforms the Funds into "insured" funds for the purpose of ERISA preemption is contrary to law and common sense. It is well settled that the extent of insurance coverage is congruent with the extent of risk assumed by the insurer, as defined by the contract between the insurer and policyholder. *Union Labor Life Insurance Co.* v. *Pireno*, 458 U.S. 119, 130 (1982). The uninsured and insured

portions are therefore separable components of the Funds' liability. *See, General Motors Corp.* v. *California State Board of Equalization*, 600 F. Supp. 76 (C.D. Cal. 1984); *cf., Metropolitan Insurance Company* v. *State Board of Equalization*, 32 Cal. 3d 649, 186 Cal. Reptr. 578, 652 P. 2d 426 (Cal. 1982). To the extent that claims do not reach the aggregate limit, the Funds are uninsured, and to that extent indirect state regulation of the Funds through insurance law is preempted by ERISA. *Metropolitan Life, supra.*[8]

The respondent insurance commissioner evidently interprets the Sixth Circuit's opinion to hold that Act 429 is deemed applicable *to the Fund as a whole*, not merely to *the insurer's coverage of excess claims*. Petitioners disagree with that construction. However, when the Court of Appeals remanded for further proceedings, it failed to clearly state the law of the case, providing inadequate guidance for the parties or the court below. By any reading of its holding, the Court of Appeals has misapplied applicable precedent.

Petitioners respectfully submit that if the court intended to hold Act 429 applicable to the *uninsured* portion of the Funds' operations, it committed fundamental error. The Funds bear the risk and liability, and they administer, adjudicate, and pay all claims up to a predetermined level; if the Funds are not "uninsured" to this extent, it is difficult to imagine what employee welfare benefit plan, under that construction of the Sixth Circuit's analysis, *would* fall within ERISA's broad preemption clause. State regulatory authority cannot be extended to the uninsured portion of the Fund's liability without completely eviscerating ERISA's "deemer clause," which specifically prohibits the designation of an employee benefit plan "as an insurance company or insurer . . . for purposes of any law of a state purporting to regulate insurance companies. . . ." ERISA Sec.

[8]In actual experience, the claims liability limit has never been reached. Historically, therefore, all payments to beneficiaries and providers have been made by the Funds themselves.

514(b)(2)(B), 29 U.S.C. 1144(B)(2)(B). Imposing the State's minimums on the Fund's *uninsured* benefits would contravene the fundamental ERISA principle that "the private parties, not the government, control the level of benefits." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

Petitioner's alternative reading of the Sixth Circuit's decision, holding Act 429 not preempted only to the extent of the Funds' insurance coverage, nevertheless leads to problematical results. Administration of the Funds subject to the State's mandated benefits requirements *only* to the extent of Transamerica Occidental's excess loss policy would be impracticable, given the resultant conditioning of mandated benefits on an extraneous event not ascertainable at the time coverage is determined. Application of 1980 PA 429 to the contingent insured portion of the Funds' benefits liability would, at best, seriously impair the trustees' ability to satisfy their fiduciary and statutory responsibilities for sound actuarial planning and for full disclosure of coverage to plan participants (as required by ERISA, 29 U.S.C. 1022, 1024(b), 1104) — at worst, it would create an administrative imbroglio.

The Sixth Circuit's opinion is insufficiently clear as to which, if either, of the results discussed above is contemplated; although petitioners submit it is the second, both are legally and practically unsound. The Court should therefore grant this petition and rectify the Sixth Circuit's deviation from *Metropolitan Life, supra.*

II.

THE FUNDS ARE EFFECTIVELY UNINSURED FOR PURPOSES OF ERISA PREEMPTION

The optimal approach to resolving the confusion of the opinion below and harmonizing it with the principles announced in *Metropolitan Life, supra*, is to acknowledge that the Funds are *effectively uninsured*, and therefore sheltered by ERISA preemption, Sections 514(a) and (b)(2)(B); 29 U.S.C. 1144(a), 1144(b)(2)(B).

Employee benefit plans with insurance coverage and premium structures identical to the plaintiff Funds' have consistently been treated as *self-insured*. Observing the employer's "Sickness and Accident Insurance Plan" in *General Electric Company* v. *Gilbert*, 429 U.S. 125 (1976), *reh. den.*, 429 U.S. 1079, this Court stated:

> With respect to the Plan, General Electric is, in effect, a self-insurer. While General Electric has obtained, for employees outside California, an insurance policy from the Metropolitan Life Insurance Co., this policy involves the payment of a tentative premium only, subject to adjustment in the light of actual experience . . . *In effect, therefore, the Metropolitan Life Insurance Co. is used to provide administrative service of processing claims, while General Electric remains, for all practical purposes, a self-insurer.*

Id., at 128, n. 3 (emphasis added); *see also, Dawson* v. *Whaland*, 529 F. Supp. 626 nn. 3, 4 (D. N.H. 1982). The adjustable premium described by the Court above is almost identical to the "Flexible Funding" premium arrangement between the Funds and Transamerica.[9]

The Court recognized in *General Electric* v. *Gilbert, supra*, that an experience-rated premium arrangement such as the one between the Funds and Transamerica transfers only minimal actual risk to the insurer -- primarily liability for cancellation with an accumulated deficit. *See*, Arnett & Trapnell, *supra*, at p. 29.

An insurance policy is not an infallible indicator of insurance. *SEC* v. *Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959). A policyholder is insured only to the extent of the risk actually underwritten. *Group Life & Health Ins. Co.* v. *Royal Drug*, 440 U.S. 205 (1979), *reh. den.* 441 U.S. 917. In the case of the Funds, that risk is negligible — certainly a slim reed upon

[9]A portion of the premium that covers insurance of excess individual claims is not experience rated. The excess coverage for individual liability, like that for aggregate liability, see footnote 8, *supra*, has never been subject to claim.

which to circumvent the "crowning achievement" of ERISA, "the reservation to federal authority of the sole power to regulate the field of employee benefit plans, . . . [protecting] participants by eliminating the threat of conflicting and inconsistent state and local regulation." Remarks of Sen. Dent, 120 Cong. Rec. 29197 (Aug. 20, 1974), quoted at *Shaw* v. *Delta Airlines, Inc., supra,* 463 U.S. at 99.

To the extent that the Funds are essentially self-insured, with supplemental insurance coverage solely on a contingent "excess loss" basis, they should be considered ***uninsured.*** (Compared with the plans providing approximately 90 percent of benefits through group insurance policies, described in *Wadsworth* v. *Whaland*, 562 F.2d 70, 75 (CA 1 1977), *cert. denied*, 435 U.S. 980 (1978), the UFCW Funds have, to date, provided no benefits through "excess-loss" insurance.)

Congress has indicated the proper approach to distinguishing plans that are effectively uninsured or marginally insured, from those that fund benefits primarily through conventional purchased insurance policies, in relation to federal preemption of state regulation. In 1982, out of concern over underfunding of multiple employer health insurance trusts (which the Funds do not claim to be), Congress amended Sec. 514 to codify an explicit exemption from ERISA preemption. Sec. 514(b)(6), 29 U.S.C. 1144(b)(6)[10] In that legislation, Congress explicitly

[10]Sec. 514(b)(6)(A) — Notwithstanding any other provision of this section

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangaement, in addition to this title, any

Continued on page 12

distinguished "fully insured" multiple employer welfare arrangements from plans that are not fully insured. In Sec. 514(b)(6)(A)(i), state insurance regulation of fully insured plans is preempted, with limited exceptions; conversely, Sec. 514(b)(6)(A)(ii) expressly permits the states to regulate multiple employer welfare arrangements that are not fully insured directly through their insurance laws. *See, Conference Committee Report*, 97th Cong., 2d Sess., 128 Cong. Rec. H. 10650 (daily ed. Dec. 21, 1982).

The obvious rationale is that an express grant of state authority to regulate fully-insured plans was unnecessary, because the "insurance savings clause," Sec. 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), permits the states to guarantee the financial integrity of such plans indirectly through regulation of their principal asset — the insurance policy. Where Congress intended to permit an exception to ERISA's preemption of state regulation of partially insured (or effectively non-insured) plans through insurance laws, it expressly said so, in Sec. 514(b)(6)(A)(ii). That section would be superfluous if, as the Court of Appeals holds, the states could already regulate the terms of partially-insured plans through their insurance carriers under the preceding provisions of Section 514. *See*, Kilberg & Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex. L. Rev., 1313, 1319 (1984).

Continued from page 11

> law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.
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> • • •
>
> (D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

29 U.S.C. 1144 (b)(6).

By designating the Funds as "insured," and consequently subject to Michigan's mandated substance-abuse coverage law — even as to the excess coverage — the Sixth Circuit has misconstrued, misapplied, and "misapprehended the scope" of the holding in *Metropolitan Life*. Intervention and reversal by this Court is therefore appropriate. *See, e.g., Schlude* v. *Commissioner*, 372 U.S.. 128, 129-30 (1963); *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579, 581 (1976). An approach which acknowledges the "comprehensive and reticulated" structure of ERISA, *Nachman Corp.* v. *Pension Benefit Guarantee Corp.*, 446 U.S. 359, 361 (1980), *reh. den.* 448 U.S. 908, harmonizing Congress' desire for broad federal preemption with its solicitude for local insurance regulation, is one which treats marginally insured plans as effectively *uninsured* and reserves for state insurance regulation those plans which maintain as their principal security an insurance policy.

CONCLUSION

The petition for a writ of certiorari should be granted. The Court of Appeals has misapplied the recent holding in *Metropolitan Life, supra*, and in so doing has decided an important federal preemption question contrary to applicable decisions of this Court.

Respectfully submitted,

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October 15, 1985

APPENDIX

A. Opinion of the United States Court of Appeals for the Sixth Circuit, *Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund, et al.* v *Nancy A. Baerwaldt, et al.*, 767 F.2d 308, Case No. 83-1570, July 19, 1985.

No. 83-1570.

UNITED STATES COURT OF APPEALS

Sixth Circuit.

Argued Sept. 18, 1984

Decided July 19, 1985.

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS and Food Employers Health and Welfare Fund, and the Board of Trustees thereof; and Michigan United Food and Commercial Workers Unions Drug and Mercantile Employees Welfare Fund, and the Board of Trustees thereof, Plaintiffs-Appellees,

v.

NANCY A. BAERWALDT, Commissioner of Insurance of the State of Michigan; Jean Carlson and Thomas Pierson, Deputy Commissioners of Insurance of the State of Michigan; and the Bureau of Insurance of the State of Michigan, Defendants-Appellants.

Frank J. Kelley, Atty. Gen. of Mich., Lansing, Mich., William A. Chenoweth, Asst. Atty. Gen. (argued), for defendants-appellants.

Theodore Sachs (argued), Detroit, Mich., for plaintiffs-appellees.

Before KEITH, Circuit Judge, and PECK and BROWN, Senior Circuit Judges.

BAILEY BROWN, Senior Circuit Judge.

Plaintiffs are two voluntary, unincorporated employee benefit trust funds, and the trustees thereof. The plaintiff plans were

established to provide health and welfare benefits to participating union employees and their beneficiaries and are "employee welfare benefit plans" as defined by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461. Defendants are the Michigan Bureau of Insurance, Michigan's Commissioner of Insurance and her deputy commissioners.

The plaintiffs brought this action seeking to invalidate Michigan Public Act 429 of 1980, which required that all health insurance policies issued in Michigan provide certain levels of substance abuse coverage. Plaintiffs contended that Act 429, as applied to plaintiffs, was pre-empted by ERISA and therefore was unconstitutional under the Supremacy Clause. Plaintiffs also contended that Act 429 impermissibly interfered with the freedom of unions and employers to bargain freely and therefore was pre-empted by the National Labor Relations Act (NLRA).

The district court, 572 F.Supp. 943 (D.C. Mich. 1983), granted plaintiffs' motion for summary judgment and held that Public Act 429 was pre-empted by both the ERISA and the NLRA. In light of the Supreme Court's recent opinion dealing directly with these issues, *Metropolitan Life Insurance Company* v. *Massachusetts*, —— U.S. ——, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), we reverse.

I

The plaintiff plans are voluntary, unincorporated employee benefit trust funds established pursuant to the Labor Management Relations Act for the purpose of providing health and welfare benefits to covered employees of participating employers and their dependents. To accomplish this goal, the plans purchased group insurance policies from insurer Transamerica Occidental Life Insurance Company (Occidental). Through a contract with Occidental, the plans pay all the health and welfare benefits provided under the group policies up to an

agreed upon amount (termed "claims liability limit"). After the claims liability limit is reached, Occidental is liable for payment of additional benefits under the applicable policies. Thus, the plaintiff plans are self insured up to the claims liability limit, beyond which they are insured for excess or catastrophic loss. Occidental does, however, fully administer the plans as agent for the plans.

This action was precipitated by the Michigan legislature's enactment of 1980 Michigan Public Act No. 429, which required every insurer offering health insurance policies within the state to provide coverage for substance abuse. Mich.Comp.Laws Ann. § 500.3425 (1983).[1] Act 429 was enacted as part of Michigan's continuing effort to deal with the problem of drug and alcohol abuse. The state estimates that approximately 750,000 of its citizens need services for drug abuse problems. In addition to the human suffering associated with drug and alcohol abuse, substance abuse results in absenteeism, increased health and welfare expenditures, property damage and accidents, and medical expenses — the annual cost of which is estimated to approach two billion dollars in Michigan alone. Additionally, the cost of lost productivity stemming from substance abuse exceeds $700 million annually in Michigan. By requiring that all insurance policies issued within the state provide specified levels of substance abuse coverage, the state hoped to encourage earlier treatment of drug and alcohol problems and to decrease the cost of abuse coverage by spreading the cost across a larger population.[2]

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[1] Act 429 provides in part:

Each insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all contracts for, group and individual hospital, medical, surgical expense-incurred health insurance policies other than limited classification policies.

Mich.Comp.Laws Ann. § 500.3425(1) (1983).

[2] If the statutorily required substance abuse coverage increased the premium cost by three percent or more, then Act 429 provides that the master policy holder has the option of declining the increased substance abuse coverage. Mich.Comp.Laws Ann. § 500.3425(2) (1983).

Although the plaintiff plans include some coverage for substance abuse treatment, the plans do not meet the requirements of Act 429. Fearing loss of its ability to do business in Michigan, Occidental informed the plaintiff plans that Occidental intended to require the plans to include the benefits specified in Act 429, contrary to the wishes of the plans' trustees. Because the plans' trustees did not wish to amend the plans in compliance with Act 429, plaintiffs filed this action against the Michigan Commissioner of Insurance and others, seeking a declaratory judgment that Act 429 is preempted by ERISA and the NLRA and therefore is inapplicable to the plaintiff plans.

II.

ERISA, 29 U.S.C. §§ 1001-1461, is a comprehensive statutory scheme designed to promote and protect the interests of employees and their beneficiaries in employee benefit plans.[3] See 29 U.S.C. § 1001. In formulating ERISA, Congress imposed upon welfare benefit plans a number of reporting and disclosure requirements, 29 U.S.C. §§ 1021-1031, 1101-1104; but Congress did "not attempt to regulate the substantive content of welfare-benefit plans," *Metropolitan Life Insurance Company v. Massachusetts*, —— U.S. ——, ——, 105 S.Ct. 2380, 2385, 85 L.Ed.2d

[3]An "employee welfare benefit plan" is any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).
29 U.S.C. § 1002(1).
An "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.
29 U.S.C. § 1002(3).

728 (1985). Although ERISA does not dictate the substantive content of welfare benefit plans, ERISA does contain a broad preemption clause providing that, unless certain exceptions apply, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).[4] This ostensibly broad pre-emption clause is limited, however, by an insurance saving clause, 29 U.S.C. § 1144(b)(2)(A). The insurance saving clause states that, with one exception, nothing in ERISA "shall be construed to exempt or relieve any person from the law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

Even a cursory reading of both the preemption clause and the saving clause reveals the conflict between them. While the pre-emption clause dictates that ERISA supersede all state laws relating to employee benefit plans, which plans include insurance benefits, the saving clause dictates that ERISA not be construed to excuse compliance with state insurance laws. The complication created by this conflict is further confused by the deemer clause, an exception to the saving clause. The deemer clause states:

> Neither an employee benefit plan . . . nor any trust

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[4] 1144. *Other Laws*

(a) [PRE-EMPTION CLAUSE] Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . . (b)(2)(A) [SAVING CLAUSE] Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) [DEEMER CLAUSE] Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . ., nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking *for purposes of any law of any State purporting to regulate* insurance companies, *insurance contracts,* banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B) (emphasis added).

As can be gathered from this skeletal recital of ERISA's pertinent passages, portions of the Act are convoluted and seemingly contradictory. We find ourselves able to resolve ERISA's internal conflicts, however, because the Supreme Court has explicitly laid out a trial [sic] for us. In *Metropolitan Life Insurance Company v. Massachusetts,* —— U.S. ——, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), the Supreme Court faced precisely the issue that confronts us in the case at bar and upheld the challenged state statute. The Commonwealth of Massachusetts had enacted a statute requiring that all insurance policies issued to Massachusetts residents provide certain levels of coverage for the treatment of mental illness. The Massachusetts statute was challenged by insurance companies that contended that the statute was preempted by both ERISA and the NLRA, and thus was invalid. Justice Blackmun, writing for a unanimous court,[5] first noted that states had long regulated insurance, including group health insurance. The Massachusetts insurance statute was characterized by the Court as a "mandated-benefit law," which requires "an insurer to provide a certain kind of benefit to cover a specified illness or procedure whenever someone purchases a certain kind of insurance." *Id.* at —— , 105 S.Ct. at 2383. The Court concluded that the Massachusetts mandated-benefit law related to an employee benefit plan within the meaning of the pre-emption clause, 29 U.S.C. § 1144(a). *Id.* at ——, 105 S.Ct. at 2388. The Court also

[5]Because Justice Powell did not take part in the decision, the vote was 8-0.

found that the Massachusetts mandated-benefit law regulated the terms of certain insurance contracts and therefore seemed to be saved from pre-emption by the saving clause because the statute was a law "which regulates insurance," 29 U.S.C. § 1144(b)(2)(A). *Id.* Acknowledging that the preemption and the saving clauses were "not a model of legislative drafting," *Id.*, the Court then explored the saving clause and its relationship to the deemer clause and concluded that:

> [b]y exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.

Id. at ——, 105 S.Ct. at 2390. The Court then held that "mandated-benefit laws . . . are saved from pre-emption by the operation of the saving clause," *Id.* at ——, 105 S.Ct. at 2392 (footnote omitted); therefore, "[i]f a state law 'regulates insurance,' as mandated-benefit laws do, it is not preempted [by ERISA]." *Id.* at ——, 105 S.Ct. at 2393.

As further support for its conclusion that the Massachusetts mandated-benefit law was a valid exercise of state power, the Court looked to the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, which states in part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . .

15 U.S.C. § 1012(b). The Court found that "mandated-benefit laws are state regulation of the 'business of insurance'" within the meaning of the McCarren-Ferguson Act and thus are a

legitimate means for state legislation. —— U.S. at ——, 105 S.Ct. at 2390.

Applying the Supreme Court's reasoning to the case at bar, we can only conclude that Act 429, by virtue of ERISA's saving clause, is not pre-empted by ERISA. Like the Massachusetts statute, Act 429 is a mandated-benefit law, and as such is saved from federal pre-emption by ERISA's saving clause. *Metropolitan Life Insurance Company* v. *Massachusetts*, —— U.S. at ——, 105 S.Ct. at 2392. We hold therefore that Act 429 is not preempted by ERISA. The "stop-loss" nature of the plans does not alter our conclusion. As the Supreme Court recognized, the *Metropolitan Life* decision "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." *Id.* According to the Complaint's description of the plans, the plans include an arrangement whereby the plans pay premiums to Occidental to insure that Occidental will pay all benefits in excess of the claims liability limit under the group policies. As long as the plans purchase insurance from "an insurer offering health insurance policies in" Michigan, the policies must include the substance abuse coverage specified by Act 429.

III.

We now turn to the second major issue on appeal. In granting the plaintiffs' motion for summary judgment, the district court stated in a footnote that an alternative basis for invalidating Act 429 was that, in the district court's view, Act 429 was pre-empted by the NLRA, 29 U.S.C. § 151 *et seq.* We hold that, on the contrary, Act 429 is not pre-empted by the NLRA.

Whether mandated-benefit laws deprive parties of the right to negotiate freely the terms of their collective bargaining agreement and thus are pre-empted by the NLRA was also determined by the Supreme Court in *Metropolitan Life Insurance Company* v. *Massachusetts*, —— U.S. ——, 105 S.Ct. 2380,

85 L.Ed.2d 728 (1985). The Court recognized that unionized workers and employers are subject to minimum labor standards imposed by both federal and state law. *Id.* at ——, 105 S.Ct. at 2396.

> [These] minimum state labor standards affect union and non-union employees equally, and neither encourage nor discourage the collective-bargaining processes that are the subject of the NLRA. Nor do they have any but the most indirect effect on the right of self-organization established in the Act. Unlike the NLRA, mandated-benefit laws are not designed to encourage or discourage employees in the promotion of their interests collectively; rather, they are in part "designed to give specific minimum protections to *individual* workers and to ensure that *each* employee covered by the Act would receive" the mandated health insurance coverage.

Id. (quoting *Barrentine* v. *Arkansas Best-Freight System, Inc.*, 450 U.S. 728, 739, 101 S.Ct. 1437, 1444, 67 L.Ed.2d 641 (1981)) (emphasis in original). Furthermore, the NLRA's legislative history does not suggest:

> that Congress intended to disturb the myriad state laws then in existence that set minimum standards, but were unrelated in any way to the processes of bargaining or self-organization. To the contrary, . . . Congress developed the framework for self-organization and collective bargaining of the NLRA within the larger body of state law promoting public health and safety.

Id. at ——, 105 S.Ct. at 2398. Because the purpose of Massachusetts' mandated-benefit law was to implement the Commonwealth's policy of providing mental health care to its residents, the Court found the law was a "valid and unexceptional exercise" of Massachusetts' police power. *Id.* at ——, 105S.Ct. at 2399. The Court concluded that Massachusetts' mandated-benefit law, "like many laws affecting terms of employment, potentially limits an employee's right to choose one thing by requiring

that he be provided with something else, it does not limit the rights of self-organization or collective bargaining protected by the NLRA, and is not pre-empted by that Act." *Id.*

Michigan's Act 429, like Massachusetts' mandated-benefit law, evolved out of the state's concern for the welfare of its citizens. Like the Massachusetts law, Act 429 "does not limit the rights of self-organization or collective bargaining protected by the NLRA," *Id.* Therefore, on the authority of ***Metropolitan Life Insurance Company*** v. ***Massachusetts***, we hold that Act 429 is not pre-empted by the NLRA.

IV.

In conclusion, we hold that Michigan's Act 429 is not preempted by either ERISA or the NLRA. Consequently, we reverse the district court's grant of the plaintiffs' motion for summary judgment and remand the cause to the district court for further proceedings consistent with this opinion.

B. Opinion of the United States District Court, Eastern District of Michigan, Southern Division, *Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund, et al.* v. *Nancy A. Baerwaldt, et al.*, 572 F. Supp. 943, Case No. 82-73821, as amended September 28, 1983.

Civ. A. No. 82-73821
UNITED STATES DISTRICT COURT,
E.D. MICHIGAN, S.D.
June 16, 1983.
As Amended Sept. 28, 1983.

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS and Food Employers Health and Welfare Fund, et al., Plaintiffs,

v.

NANCY A. BAERWALDT, Commissioner of Insurance of the State of Michigan, et al., Defendants.

Theodore Sachs, I. Mark Steckloff, Detroit, Mich., for plaintiffs.

Harry G. Iwasko Jr., William A. Chenoweth, Lansing, Mich., for defendants.

OPINION

FEIKENS, Chief Judge.

This suit is before me on defendants' motion to dismiss the complaint and plaintiffs' motion for summary judgment. At issue here are questions of federal jurisdiction and ERISA[1] preemption.

I. FACTUAL BACKGROUND

Plaintiffs are health and welfare benefit trust funds established under the Labor Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 186(c), and subject to ERISA.[2] Defend-

[1]The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*

[2]29 U.S.C. §§ 1002(1), (37), and 1003 provide for the plans' coverage.

ants are the Michigan Commissioner of Insurance, two deputy commissioners, and the Michigan Bureau of Insurance. Plaintiffs bring suit for declaratory and injunctive relief.

In 1980, the Michigan Insurance Code was amended by the addition of 1980 P.A. 429 (M.C.L.A. §§ 500.3425, 500.3609 and 500.3609a), which requires that all group disability insurance policies issued, delivered, or renewed in Michigan include a certain amount of coverage for substance abuse treatment. Although plaintiffs have obtained some coverage for substance abuse treatment in their existing policies, the coverage provided does not meet the requirements of the 1980 Act. Plaintiffs ask that the 1980 statute be declared unconstitutional as applied to them, and that defendants be enjoined from its enforcement.

Plaintiffs each have contracts with Occidental Life Insurance Company ("Occidental") providing that each fund will be liable for the payment of benefits to covered employees up to a maximum dollar amount. Once that amount has been exceeded, Occidental assumes responsibililty for benefit payments. This arrangement is sometimes called a "stop-loss" plan. Occidental also administers the plans as agent for the funds.

No actions against either plaintiffs or Occidental have been brought by the Michigan Attorney General's Office.

II. THE MOTIONS

Plaintiffs' summary judgment motion urges that 1980 P.A. 429 is preempted by ERISA, and is therefore unconstitutional under the Supremacy Clause of the Federal Constitution.[3] Plaintiffs also argue that even if ERISA does not preempt 1980 P.A. 429 when it is applied to benefit coverage provided by Occidental, it cannot be applied to that portion of plaintiffs' plans which is self insured.

Defendants' motion to dismiss has two principal compo-

[3]At oral argument, plaintiffs also urged preemption by virtue of the National Labor Relations Act ("NLRA"), 29 U.S.C. § 151 *et seq.*

nents: First, they claim that federal subject matter jurisdiction has not been properly invoked. Second, defendants say plaintiffs have failed to state a claim because ERISA by its own terms saves the Michigan statute, which they say regulates insurance, from preemption.

Deciding the jurisdictional question first, I find that I may properly consider the complaint brought before me. On the merits, I hold that ERISA preempts 1980 P.A. 429 as applied to plaintiffs via their purchase of excess liability insurance from Occidental. My reasons for these holdings follow.

III. THE JURISDICTIONAL QUESTION

Defendants assert that in bringing this action, plaintiffs cannot convert what would be a defense in a state suit into a ground for federal question jurisdiction. Thus, defendants say, plaintiffs have not properly pleaded jurisdiction in this court pursuant to 28 U.S.C. §§ 1331 or 1337.[4] Both because I find the complaint in this suit is not a preemptive strike, and because I believe ERISA gives plaintiffs an independent basis for suit, I reject defendants' argument.

Federal question jurisdiction must be founded upon the allegations in a complaint, not on defenses to the action that might be raised. *Gully v. First National Bank*, 299 U.S. 109, 57 S.Ct. 96, 81 L.Ed. 70 (1936). Defendants properly observe that this rule should not be subverted by potential defendants enterprising enough to start a declaratory or injunctive lawsuit before they are sued. Thus, where there is a preemptive strike, courts do not look to the allegations of the complaint, but the nature of the threatened action. The United States

[4]28 U.S.C. § 1331 provides: "The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws or treaties of the United States." 28 U.S.C. § 1337(a) provides in part: "The district courts shall have original jurisdiction of any civil action or proceeding arising under any Act of Congress regulating commerce . . ." ERISA is "an Act of Congress regulating commerce," (See 29 U.S.C. § 1001(b), (c)). If the suit before me "arises under" ERISA, therefore, jurisdiction is conferred by either 28 U.S.C. §§ 1331 or 1337(a).

Court of Appeals for the Sixth Circuit recognized this rule in *Michigan Savings & Loan League v. Francis,* 683 F.2d 957 (6th Cir.1982).

In *Francis,* the Sixth Circuit affirmed the lower court's dismissal of the action for lack of jurisdiction. *Francis* was brought by a group of federally chartered savings and loan associations which wanted to avoid being subject to Michigan's Mortgages Lending Act. Plaintiffs alleged the federal Home Owners Loan Act ("HOLA") preempted the Michigan statute. At the time they brought the action, plaintiffs had already been notified that they would be fined by Michigan's Commissioner for Financial Institutions. HOLA has no specific preemption language. Judge Keith, relying on *Public Service Commission v. Wycoff Company, Inc.,* 344 U.S. 237, 73 S.Ct. 236, 97 L.Ed. 291 (1952),[5] held that the federal right asserted was really in the nature of a defense to the imminent state court action, and that therefore federal question jurisdiction was lacking.

Francis is distinguishable from the instant case. First, the HOLA statute before Judge Keith and the ERISA statute before me are dissimilar, inasmuch as ERISA has express language of preemption, where HOLA does not. Second, in the

[5]In *Wycoff,* the Supreme Court held that a company in the business of distributing films within and outside the State of Utah could obtain neither a declaration that its transportation of films within Utah was in furtherance of interstate commerce, nor an injunction preventing Utah's Public Service Commission from interfering with their film distribution. Observing that no state suit had yet been launched, the Court emphasized that the controversy was not ripe for review, and that no showing of irreparable harm had been made. The Court also observed as a general proposition:

> Where the complaint in an action for declaratory judgment seeks in essence to assert a defense to an impending or threatened state court action, it is the character of the threatened action, and not of the defense, which will determine whether there is a federal question jurisdiction. . . . If the cause of action, which the declaratory defendant threatens to assert, does not itself involve a claim under federal law, it is doubtful if a federal court may entertain an action for a declaratory judgment establishing a defense to that claim.

Id. at 248, 73 S.Ct. at 242.

Francis case, a state court suit against plaintiffs was in the offing. Here, no state court determination is being derailed; plaintiffs are not threatened with suit and are not even the potential defendants to such an action. It is Occidental which is the potential defendant. Because Occidental has chosen to avoid the risk of state prosecution under 1980 P.A. 429 by forcing plaintiffs to pay for increased substance abuse coverage, plaintiffs are in effect being saddled with what the consequences of a negative state court determination against Occidental would be, without having the opportunity to litigate their position.

Unlike the situation in *Public Service Commission v. Wycoff, supra*, fn 4, this controversy is ripe for review. Where, as here, plaintiffs base their complaint for both declaratory and injunctive relief from a state statute upon a claim of federal preemption, I hold that plaintiffs are seeking to vindicate a federal right, not just ward off a state suit. *See Stone & Webster Engineering Corporation v. Ilsley*, 690 F.2d 323 (2d Cir.1982). They therefore have properly pleaded federal question jurisdiction under 28 U.S.C. §§ 1331 and 1337.

I also hold that plaintiffs have standing,[6] and have alleged a valid alternative source of jurisdiction. ERISA states that a civil action may be brought

> by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provisions of this subchapter or the terms of the plan . . . 29 U.S.C. § 1132(a)(3),

and that

> [T] district courts of the United States shall have juris-

[6]This discussion addresses the jurisdictional issue as argued and briefed, notwithstanding the entry of an April 11, 1983 stipulation and order adding the plans' trustees as parties which may have mooted the following points.

> diction, without respect to the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action. 29 U.S.C. § 1132(f).

Defendant challenges the applicability of this ERISA provision, saying plaintiff employee benefit plans are not "participants," "beneficiaries" or "fiduciaries" under its language.

I do not read the quoted provision in such a limiting manner. While participants, beneficiaries, and fiduciaries who might otherwise not clearly have standing to bring suit in federal court to enjoin violations of the Act are the only parties addressed, I do not believe the provision's language should be read to exclude a non-fiduciary plan itself from suing for an injunction, and obtaining federal jurisdiction by presenting a question arising under ERISA. ERISA § 1132(d)(1) buttresses the plan's standing. It provides: "an employee benefit plan may sue or be sued under this subchapter as an entity." Although this later provision does not confer federal jurisdiction, and does not define the types of suits which may be brought by a plaintiff plan, I read it, together with § 1132 and ERISA's clear legislative preemption mandate, to sanction the type of suit brought before me.[7]

IV. ERISA PREEMPTION

Three ERISA clauses are the battleground for the parties' preemption dispute. They are commonly known as: (1) the preemption cluase; (2) the "saving" clause; and (3) the "deemer" clause. In order, they provide as follows:

1. *Preemption Clause*

> Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede

[7]My conclusion is consistent with that reached by the United States Court of Appeals for the Ninth Circuit in *Fentron Industries, Inc. v. National Shopmen Pension Fund*, 674 F.2d 1300 (9th Cir. 1982). The court in *Fentron* specifically found that an employer had standing to assert its claim under ERISA, despite § 1132(e)(1)'s omission of "employers" from the list of those with standing to sue under ERISA.

> any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) . . . and not exempt under section 1003(b) . . . 29 U.S.C § 1144(a).
>
> 2. *Saving Clause*
>
> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. 29 U.S.C. § 1144(b)(2)(A).
>
> 3. *Deemer Clause*
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State, purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.[8] 29 U.S.C. § 1144(b)(2)(B).

Defendants' position is that even if 1980 P.A. 429 "relates to" an employee benefit plan so as to come under the broad preemption of the preemption clause, the statute is "saved" by the clause which excepts laws regulating insurance from invalidity. Plaintiffs read the deemer clause to prevent employee benefit plans from being regulated as if they were insurance companies, but do *not* read it to preclude even indirect effects of insurance laws. Primarily, defendants see the deemer clause as preventing employee benefit plans from being saddled with the regulations insurance companies are prey to; the deemer

[8]Also relevant to the preemption issue are the recent amendments to Section 1144, which will be discussed *infra*. Neither party cited these amendments in its briefs.

clause does not, in defendants' view, make employee benefit plans into a special class of customer for insurance companies. As additional authority, defendants cite the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, which states in part "No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such act specifically relates to the business of insurance . . ." 15 U.S.C. § 1012(b). ERISA § 1144(d) provides that ERISA does not modify or supersede any other federal law.

Plaintiffs' position is that enforcement of the 1980 Act would regulate the terms and conditions of plaintiffs' plans. Plaintiffs assert that neither direct nor indirect regulation is permissible. They read the deemer clause as making clear that states cannot prescribe plan terms in the guise of regulating insurance. Plaintiffs point out that if the deemer, saving, and preemption clauses allow for an act like 1980 P.A. 429, then the only option for plans hoping to avoid mandatory forms of coverage imposed by states would be to be self insured. Plans would then differ in the requirements made of them by virtue of their capacity to self insure. This would defeat ERISA's goal of uniform standards applicable to all employee benefit plans.

As a final point, plaintiffs say that even if 1980 P.A. 429 is permissible when invoked against an insurance company which offers group life coverage to an ERISA plan, it should not apply to a self-insured plan. They characterize their stop-loss coverage as being, in effect, self insurance up to the maximum loss figure when Occidental begins to assume coverage. Because of my holding in this case, I do not reach this last issue.

V. ANALYSIS

I agree with plaintiffs' view that the statute in question impermissibly dictates the terms and conditions of an employee benefit plan. I believe that ERISA was intended to insulate

multi-employer welfare benefit plans formed pursuant to collective bargaining agreements from any state laws that might prescribe the benefits they are to afford. Although the broad stroke of § 1144's preemption clause is modified by the saving clause's caveat that "nothing in this title shall be construed to exempt or relieve any person[9] from any law of any state which regulates insurance, banking, or securities," I do not think that clause was aimed at preserving state statutes which more than tangentially affect employee benefit plans.

ERISA's language and legislative history make clear that it was enacted to help insure employees a certain modicum of security in the expectation of benefits they held from private pension and welfare plans. It is also apparent that ERISA was carefully devised to insure that the regulations it imposed upon employee pension and benefit plans would not strangle the growth of these plans.[10] Implicit in the whole purpose of

[9]"Person" is defined in ERISA as "an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization." 29 U.S.C. § 1002(9). I note that the meaning of "trust" in this list is somewhat ambiguous, and I have some doubt as to whether the employee benefit plans before me were meant to fall within the definition of "person" at all.

[10]In its synopsis of ERISA's purposes, the House Committee on Education and Labor (hereinafter "House Committee") observed:

> The Employee Benefit Security Act as reported by the Committee is designed to remedy certain defects in the private retirement system which limit the effectiveness of the system in providing retirement income security. The primary purpose of the bill is the protection of individual pension rights, but the committee has been constrained to recognize the voluntary nature of private retirement plans. The relative improvements required by this Act have been weighed against the additional burdens to be placed on the system. While modest cost increases are to be anticipated when the Act becomes effective, the adverse impact of these increases have been minimized. Additionally, all of the provisions in the Act have been analyzed on the basis of their projected costs in relation to the anticipated benefit to the employee participant. In broad outline, the bill is designed to:
>
> (1) establish equitable standards of plan administration;
>
> (2) mandate minimum standards of plan design with respect to the vesting of plan benefits;

the Act is a desire to encourage private pension and welfare plans by promulgating uniform, reasonable, and non-oppressive federal requirements.

In my view, this nurturant attitude towards private plans must be carefully considered in determining the preemption issue before me. Preemption of a state statute is demanded by the Supremacy Clause of the United States Constitution (Art. VI, Cl. 2) where state and federal laws are inconsistent. A state law need not directly contradict a federal statute to be preempted; state laws which impinge on an area carved out by Congress as an exclusive federal domain are unenforceable as well. *Fidelity Savings & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 102

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(3) require minimum standards of fiscal responsibility by requiring the amortization of unfunded liabilities;

(4) insure the vested portion of unfunded liabilities against the risk of premature plan termination; and

(5) promote a renewed expansion of private retirement plans and increase the number of participants receiving private retirement benefits.

H.R. Rep. No. 533, 93 Cong., 2d Sess. (hereinafter "House Report"), reprinted in 1974 U.S. Code Cong. & Ad.News 4639-40, continues:

The Committee believes that the legislative approach of establishing minimum standards and safeguards for private pensions is not only consistent with retention of the freedom of decision-making vital to pension plans, but in furtherance of the growth and development of the private pension system. At the same time, the Committee recognizes the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many.

The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations. In adopting this approach, the Committee believes it has designed a bill, which, like the National Labor Relations Act, the wage-hour laws and other labor standards laws, brings the workers' interests up to parity with those of employers. This legislation strikes an appropriate and equitable balance between two opposing schools of thought — those who advocate complete and stringent control of private pensions and those who oppose any form of government supervisory or regulatory control.

House Report, Op. Cit., at 4647.

S.Ct. 3014, 73 L.Ed.2d 664 (1982); *Malone v. White Motor Corp.*, 435 U.S. 497, 98 S.Ct. 1185, 55 L.Ed.2d 443 (1978); *Kapuscinski v. Plan Administrator, et al.*, 658 F.2d 427 (6th Cir. 1981); *Carpenters Pension Trust for Southern California v. Kronschnabel*, 460 F.Supp. 978 (C.D.Cal.1978), *aff'd* 632 F.2d 745 (9th Cir.1980). By generally disallowing state regulations that might enhance protections for employees within any particular state, Congress was making a judgment that the greater national good called for both a minimum and maximum on the regulation of employee benefit plans.[11]

Informed as I am by the general intent of ERISA, I would construe the saving and deemer clauses differently than some of my fellow judges have done.[12] Certain other courts, when

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[11]Discussing preemption, Congressman Dent said in the final House debate on the Bill, "I wish to make note of what is to many *the crowning achievement of this legislation, the reservation to Federal authority of the sole power to regulate the field of employee benefit plans.* With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong.Rec. (HR) 29197 (August 20, 1974) (emphasis supplied), *quoted in General Motors Corp. v. Buha*, 623 F.2d 455, 459 (6th Cir.1980). This was not the case when the Supreme Court considered the preemptive effect of the federal Welfare and Pensions Plan Disclosure Act (superseded) in *Malone v. White Motor Corp.*, 435 U.S. 497, 98 S.Ct. 1185, 55 L.Ed.2d 443 (1978). There, the Court refused to find that that statute, ERISA's predecessor, and the NLRA preempted state regulation of pension plans. Instead, the Court pointed to language in the legislative history of that Act which indicated Congress "envisioned the exercise of state regulation over pension funds." 435 U.S. 497, 512, 98 S.Ct. 1185, 1194, 55 L.Ed.2d 443. The court in *Malone* noted, however, that Congress "came to a quite different conclusion" where ERISA was concerned. According to the Court's dicta, ERISA was enacted largely in response to perceived inadequacies in the prior scheme.

[12]I come to the saving clause directly, rather than discussing the preemption clause at length, because I think it is clear that 1980 P.A. 429 "relates to" an employee welfare benefit plan, and is thus preempted *unless* it falls under the enumerated exceptions of the saving clause. As the Court of Appeals for the Second Circuit observed in *Stone & Webster Engineering Corp. v. Ilsley, supra*, "A state law 'relates to' an employee benefit plan and is subject to preemption whenever it 'purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans.' " *Id.* at 329, *quoting* from 29 U.S.C. § 1144(c)(2). I note that defendants all but conceded the relatedness of the statute in question in their brief.

faced with statutes denominated insurance regulations, have been loath to allow preemption when these statutes were applied against an insurance company, rather than directly against a plan.

In *Wadsworth v. Whaland,* 562 F.2d 70 (1st Cir.1977), for example, the First Circuit held that a New Hampshire statute requiring all group health insurance policy issuers to provide policy coverage for mental illness was not preempted.[13] Plaintiffs in *Wadsworth* had contended that the statute "impermissibly regulate[d] employee benefit plans by indirectly regulating the content of the group insurance policies which the funds purchase, and that ERISA preempt[ed] any state regulation of employee benefit plans. The State of New Hampshire respond[ed] that ERISA was not intended to preempt any state law unless that law directly conflict[ed] with or duplicate[d] the regulatory provisions of ERISA." *Id.* at 76.

Rejecting plaintiff's argument, the court in *Wadsworth* construed the deemer clause as prohibiting only the *direct* regulation of an employee benefit plan as an insurance company, and found that the saving clause would be meaningless without including the New Hampshire statute under its protection. I disagree.

Unlike the court in *Wadsworth*, I do not view the saving and deemer clauses as preserving a back door approach to control of a plan's terms and conditions through "indirect" regulation. If Congress had meant for the deemer clause to have such consequences, it would have used more specific language.[14] Furthermore, the distinction between direct versus indirect

[13] *See also Attorney General v. Travelers Insurance Co.,* 385 Mass. 598, 433 N.E.2d 1223 (1982); *cf. General Split Corp. v. Mitchell,* 523 F.Supp. 427, 431 (E.D. Wis. 1981); and *Russo v. Boland,* 103 Ill.App.3d 905, 59 Ill.Dec. 537, 431 N.E.2d 1294 (1982).

[14] In the 1983 Amendments to § 1144, in fact, Congress does distinguish between some fully insured and non-fully insured plans, but its distinction does not affect plans like the one before me.

regulation has been rejected, albeit in cases not involving the saving and deemer clauses but only the preemption clause, by the Supreme Court and the Court of Appeals for the Sixth Circuit.[15] There are sound public policy reasons for rejecting the distinction. As the court in *Metropolitan Life Insurance Company v. Insurance Comm'r,* 51 Md.App.122, 441 A.2d 1098 (Spec.App.1982), noted:

> Although it was the clear intent of the Congress not to interfere in the regulation of insurance by the states, we see no intent to extend that policy to permitting state regulation of the terms and conditions of employee benefit plans. [One article treating the subject] observes:
>
> > If states are permitted to require employee benefit plans to provide substantive benefits under the guise of insurance regulation, the result may be a Hobson's choice for employee or labor and management negotiators; either abandon the funding of benefit plans through insurance policies or be willing to accept all-encompassing uniform national contracts. For, if each state may impose its own substantive terms on the plan, the only way uniformity may be reached is by incorporating into the plan all of the benefits each state requires. This dilemma is clearly of the type that Congress sought to avoid by enacting ERISA's preemption provisions, which were formulated to re-

[15]In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981), the Supreme Court struck down a New Jersey statute prohibiting employers from setting off workers' compensation awards in their provision of pension benefits. The Court found that Congress meant to preempt the field of pension plan regulation when it adopted ERISA. The New Jersey statute, although called a workers' compensation law rather than a pension plan regulation, could not escape preemption. "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision." *Id.* at 525, 101 S.Ct. at 1907. "It is of no moment that New Jersey intrudes indirectly . . . rather than directly." *Id. See also Kapuscinski v. Plan Administrator,* 658 F.2d 427 (6th Cir. 1981).

> lieve interstate employee benefit plans of the adverse effects of cumulative or inconsistent state regulation.

Id. 441 A.2d at 1103, *quoting* Hutchinson and Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974,* 46 Chicago L.Rev. 23, 68-69 (1978).

Looking at the saving clause as a whole, I find that its purpose was to avoid unintended and wholesale preemption of important fields of state concern by making clear that statutes only incidentally affecting employee benefit plans, but not regulating their terms and conditions, were not to be ousted. In other words, ERISA's preemption clause was not meant to sweep up within it a whole range of state laws that were or could arguably be related to employee benefit plans, but were actually addressed to maintaining state control over three areas of its traditional power: banking, securities regulation, and the regulation of insurance.

The saving clause may preserve the state's power to regulate certain types of institutions important to the fabric of state life, and generally excluded from fedral regulation, but I would confine the term "regulates insurance" so as to exclude laws which do not so much monitor the insurance industry as its customers from the clause's protection.[16] As the House Committee on Labor and Education observed in a report prepared pursuant to its oversight responsibility for ERISA:

> The provisions of Section [1144] expressly reserve to federal authority the regulation of employee benefit plans subject to the jurisdiction of the Act. In electing deliberately to preclude State authority over these plans, Congress acted to insure uniformity of regulation with respect to their activities. There was a recognition of the necessity for the preservation of some State activity in this field and certain limited exceptions were made to

[16]By doing so, I believe I strike the correct balance between the McCarran-Ferguson Act and ERISA.

> the broad preemption scheme. *In general these exemptions are designed to save State law as it applies to entities which are not employee benefit plans as defined in Section [1003(a)] and not exempt under Section [1003(b)], to the extent that such regulation does not relate to employee benefit plans.* ACTIVITY REPORT OF THE COMMITTEE ON EDUCATION AND LABOR OF THE U.S. HOUSE OF REPRESENTATIVES, House Report No. 94-1785, pp. 46-47 (1/3/77), *quoted in Bell v. Employee Security Benefit Ass'n,* 437 F.Supp. 382, 387 (D.Kan.1977). (Emphasis added.)

Not every statute designated an insurance law should come within the exception carved out by Congress to ERISA's broad preemption. There are laws, however, which are more than just nominally insurance regulations. Laws which increase the cost of doing business for an insurance company may relate to or affect a plan but yet be unimpeachable because they do in fact "regulate insurance" and only tangentially affect plans; with non-preemption of such laws I would have no quarrel.

My view is supported by a reading of the saving clause in tandem with the deemer clause. I consider the deemer clause to have two main purposes. First, the clause makes clear that employee benefit plans should not be viewed as the equivalents of insurance companies, securities firms, or banks simply because they might serve some of the same functions for their beneficiaries. They are thus not subject to the same kind of *institution qua institution* regulations. Second, the clause prevents the above-mentioned institutions from "masquerading" as employee benefit plans, and thus avoiding state regulations having nothing directly to do with ERISA or the private pension and welfare benefit system. *See,* for example, *Hamberlin v. VIP Insurance Trust,* 434 F.Supp. 1196 (D.Ariz.1977); *Wayne Chemical Inc. v. Columbus Agency Service Corporation,* 567 F.2d 692 (7th Cir.1977).

Congress' newly enacted legislation also bolsters my conviction that the types of plans plaintiffs represent are immune from the permissible regulation of insurance left open by the saving clause.

Section 1144 now includes the following language:

> (6)(A) Notwithstanding any other provision of this section —
>
> (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured . . . any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —
>
> (I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions . . . and
>
> (II) provisions to enforce such standards, and
>
> (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, . . . any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter . . .
>
> (C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries . . .

At first blush, this new language might seem to support the rationale of cases finding against preemption when a statute has a direct coercive effect only upon an insurance company, but not a plan.[17] Fully insured multi-employer welfare arrange-

[17] *See* n. 13, *supra.*

ments are treated differently from non-fully insured arrangements under the § 1144 amendments. The fully insured arrangements are specifically subject to a range of state laws presumably narrower than those provided in the saving clause, whereas the non-fully insured arrangements are subject to any state laws which "regulates insurance," unless the Secretary exempts them from coverage. What constitutes regulation of insurance is not more clearly defined than in the original language of § 1144, leaving open the possibility that statutes affecting terms and conditions of multi-employer welfare benefit "arrangements" might be "saved" from preemption.

Nevertheless, I read the new statutory language to support plaintiffs' position. In an amendment to the definitional section of the Act, "multi-employer benefit arrangement" is defined in pertinent part as:

> [A]n employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1)[18] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—
>
> (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements . . . 29 U.S.C. § 1002(40)(A).

By contrast, a "multi-employer plan" is defined as one:

> (i) to which more than one employer is required to contribute,
>
> (ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

[18] 29 U.S.C. § 1002(1).

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation. 29 U.S.C. § 1002(37)(A).

Thus, plans like plaintiffs' which were established pursuant to a collective bargaining agreement form a separate class, treated differently under the Act. The new statutory language affecting multi-employer benefit plans *not* formed pursuant to a collective bargaining agreement does not reach the plans before me.

Congress had good reason for differentiating between plans which conform to a collective bargaining agreement and those which do not. First, the benefits under plans formed as a result of collective bargaining express the finely tuned give and take of the negotiating process. Second, such plans embody the goals of the NLRA, a federal statute which in and of itself has preemptive effect. As the Supreme Court observed in *Alessi v. Raybestos-Manhattan, Inc., supra*, "Employee benefit plan terms themselves become expressions of federal law, requiring preemption of intrusive state law." *Id.* 451 U.S. at 536, 101 S.Ct. at 1913.

The fact that the state law in question reflects the benign public policy of alleviating alcohol and drug dependencies is not enough to allow evisceration of the agreement embodied in the employee benefit plans before me.[19] As one court observed, "Ordinarily, preemption depends upon the effect of State law upon NLRA policy, and the fact that a state law is enacted for

[19] *Cf. Local 24, International Board of Teamsters v. Oliver*, 358 U.S. 283, 79 S. Ct. 297, 3 L.Ed.2d 312 (1959), where the Supreme Court held that Ohio's antitrust law was preempted insofar as it interfered with a collectively bargained wage agreement, but also noted that the statute before it was not a "local health or safety regulation." *Id.* at 297, 79 S.Ct. at 305. 1980 P.A. 429 is not, in my estimation, the type of "local health or safety regulation" which the *Oliver* court expressed doubt about preempting. It is not a regulation designed to deal with emergency situations and imminent threats to public health, which are so peculiarly within the police power of the state to address. Thus, I view *Oliver* as supporting preemption under the NLRA.

neutral purposes and applies outside the employment relationship cannot save it from preemption." *Attorney General v. Travelers Insurance Co.*, 385 Mass. 598, 433 N.E.2d 1223 (1982) 433 N.E.2d at 1231-1232.[20] Public Act 429 of 1980 disturbs a mandatory subject of collective bargaining; namely, the provision of health benefits. Because of its effect, it must be preempted.[21]

For the reasons stated above, I hold that 1980 P.A. 429 is preempted as it applies to multi-employer welfare benefit plans subject to ERISA, and that the State of Michigan is permanently enjoined form its enforcement against such plans.

An appropriate order may be submitted.

---

[20]In *Attorney General v. Travelers Insurance Co., supra*, the Supreme Court of Massachusetts found no preemption when faced with a similar statute. The Court relied upon three grounds for rejecting preemption: first, it found that the state law in question was of special local concern, and was not the type of law Congress contemplated preempting under the NLRA; second, as a state regulation of insurance, the law came under the protection of the McCarran-Ferguson Act, *supra*, "which establishes a congressional policy in favor of State regulation of insurance," Id. 433 N.E.2d at 1232; and finally, the statute did not directly prohibit plans from retaining the level of health benefits they had contemplated, but only imposed different benefits upon plans which sought insurance. I reject all three reasons offered against preemption. First, as I have already noted, I distinguish the type of statute before me from the type of health and public safety law the *Oliver* court recognized might not be preempted. Second, I read the McCarran-Ferguson Act, which provides for state regulation of the "business of insurance" to apply to a narrower range of state activity when read in light of ERISA. Third, I do not believe plans entered into as a result of collective bargaining should be presented with the dilemma of choosing between acquisition of insurance, and maintenance of their agreed-upon terms and conditions.

[21]Preemption by virtue of the NLRA provides an alternative basis for my holding in this case. Because the NLRA issue was raised only at oral argument, and not in plaintiffs' brief, defendants may feel disadvantaged inasmuch as they did not have a full opportunity to research NLRA preemption. Any disadvantage defendants may have suffered in presenting such an argument is of no consequence, however, because my decision to preempt stands equally upon ERISA's mandate.

C. Judgment of the United States Court of Appeals for the Sixth Circuit, *Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund, et al.* v. *Nancy A. Baerwaldt, et al.*, Case No. 83-1570, entered July 19, 1985.

UNITED STATES COURT OF APPEALS
For the Sixth Circuit
No. 83-1570

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND FOOD EMPLOYERS HEALTH AND WELFARE FUND, et al.,

Plaintiffs-Appellees,

v.

NANCY A. BAERWALDT, Commissioner of Insurance of the State of Michigan, et al.,

Defendants-Appellants.

Before: KEITH, Circuit Judge; and PECK and BROWN, Senior Circuit Judges.

JUDGMENT

ON APPEAL from the United States District Court for the Eastern District of Michigan.

THIS CAUSE came on to be heard on the record from the said District Court and was argued by counsel.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this court that the judgment of the said District Court in this case be and the same is hereby reversed and the case is remanded for further proceedings consistent with this opinion.

It is further ordered that Defendants-Apellants recover from Plaintiffs-Appellees the costs on appeal, as itemized below, and that execution therefor issue out of said District Court, if necessary.

ENTERED BY ORDER OF THE COURT
John P. Hehman, Clerk

D. Text of 1980 PA 429, Michigan Comp. Laws Ann. §§ 500.3425, .36092(a).

500.3425. *Substance abuse care coverage*

Sec. 3425. (1) Required coverage. Each insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all contracts for, group and individual hospital, medical, surgical expense-incurred health policies other than limited classification policies.

(2) Option to decline coverage. In the case of group health insurance policies, if the premium for a group health insurance policy would be increased by 3% or more because of the provision of the coverage required under subsection (1), the master policyholder shall have the option to decline the coverage required to be provided under subsection (1). In the case of individual health insurance policies, if the total premium for all individual health insurance policies of an insurer would be increased by 3% or more because of the provision of the coverage required under subsection (1) in all of those policies, the named insured of each such policy shall have the option to decline the coverage required to be provided under subsection (1).

(3) Charges, terms, conditions. Charges, terms, and conditions for the coverage required to be provided under subsection (1) shall not be less favorable than the maximum prescribed for any other comparable service.

(4) Reduction of coverage by policy terms and conditions; deductibles and copayment. The coverage required to be provided under subsection (1) shall not be reduced by terms or conditions which apply to other items of coverage in a health insurance policy, group or individual. This subsection shall not be construed to prohibit health insurance policies that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse.

(5) Minimum benefits. The coverage required to be provided under subsection (1) shall, at a minimum, provide for up to $1,500.00 in benefits for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(6) Definitions. As used in this section:

(a) "Health insurance policy" means a hospital, medical, or surgical expense incurred policy.

(b) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individual physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) "Limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(d) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individual physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnos-

tic evaluation, and referral to other services identified in a treatment plan.

(e) "Substance abuse" means that term as defined in section 6107 of Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

(7) Effective date. This section shall take effect January 1, 1982.

500.3609a. *Substance abuse care coverage*

Sec. 3609a. (1) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall offer to include in that policy a provision that the insurer will provide coverage for inpatient care for substance abuse to the extent agreed upon between the insured employer or other insured organization and the insurer, to be provided in a facility approved by the department of public health for hospitalization or treatment of substance abuse. This coverage shall be subject to the provisions of sections 3406 to 3466, except section 3425.

(2) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall include in that policy a provision that the insurer will provide coverage for intermediate and outpatient care for substance abuse, to the extent required by section 3425.

(3) This section shall take effect January 1, 1982.

E. Text of ERISA, § 514(a)-(d), 29 U.S.C. 1144(a)-(d) (irrelevant portions deleted).

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1974.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulations issued under any such law.

(2)

Supreme Court, U.S.
FILED
DEC 5 1985
JOSEPH R. SPANIOL, JR.
CLERK

No. 85-810

IN THE

SUPREME COURT OF THE UNITED STATES

October Term 1985

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND FOOD EMPLOYERS HEALTH AND WELFARE FUND, and the BOARD OF TRUSTEES thereof; and MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS DRUG AND MERCANTILE EMPLOYEES WELFARE FUND, and the BOARD OF TRUSTEES thereof,

Petitioners,

v

NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN; JEAN CARLSON and THOMAS PIERSON, DEPUTY COMMISSIONERS OF INSURANCE OF THE STATE OF MICHIGAN; and THE BUREAU OF INSURANCE OF THE STATE OF MICHIGAN,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED FOR REVIEW

DOES THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) PREEMPT §§ 3425 AND 3609a(2) OF THE MICHIGAN INSURANCE CODE WHICH PROVIDE THAT INSURANCE COMPANIES MUST INCLUDE COVERAGE FOR SPECIFIED SUBSTANCE ABUSE TREATMENT IN THEIR HEALTH AND GROUP DISABILITY POLICIES?

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STATUTES INVOLVED

The pertinent language of §§ 3425 and 3609a of the Michigan Insurance Code, MCLA 500.3425 and 500.3609a; MSA 24.13425 and 24.13609a, as added by 1980 Public Acts of Michigan 429, along with the pertinent language of § 514 of ERISA, 29 USC 1144, are set forth in the Appendix, pp 1a-6a.

STATEMENT OF THE CASE

Respondents agree, in general, with Petitioners' statement of the case. Two points, however, deserve clarification.

First, there has never been any determination that Petitioners' allegations in the Complaint are true. Respondents filed a motion to dismiss in response to the Complaint. Petitioners responded with a motion for summary judgment accompanied by two affidavits which merely stated that the allegations of the Complaint were true. Respondents countered with affidavits pursuant to FRCivP 56(f) stating that since none of the Respondents knew anything about Petitioners' factual allegations, they could not produce affidavits contradicting those Petitioners filed. The issue was brought to the district court's attention during oral argument, but the district court failed to acknowledge that the allegations were unproven. There was no trial. The district court made no findings of fact. Respondents never admitted the validity of Petitioners' allegations. Respondents raised this issue on appeal to the Court of Appeals, but the Sixth Circuit understandably did not address the issue since it reversed the district court on the law. Therefore, this case comes to this Court based only on the untested allegations of the Complaint. Respondents have not, and do not here, admit that those allegations are true. Respondents simply do not know.

Second, whether by design or otherwise, Petitioners have misleadingly characterized their contractual relationship with Transamerica. Petitioners' "Question Presented" suggests they were uninsured plans which then purchased stop loss coverage from Transamerica. Moreover, they repeatedly assert that they process and approve claims, as though Transamerica were disinterested in that aspect of their arrangement. Both characterizations contradict Petitioners' own documents.

Petitioners' connection with Transamerica did not begin with the execution of the Flexible Funding Plan Agreements (FFPAs) in 1982. For literally years prior thereto and continuing up to the time the FFPAs were executed, Transamerica insured the plan benefits under group insurance policies. These policies are referred to in, and are amended by, the FFPAs. Under the group policies, Transamerica collected premiums from Petitioners from which it paid the benefits specified in the group policies. The FFPAs altered this arrangement by providing that benefits would be paid from funds held in Petitioners' names, rather than from the premiums Transamerica received from Petitioners. Because Michigan law was changed in December 1981 to exclude administrative service contracts from the gross premium tax, execution of the FFPAs in 1982 permits Transamerica to avoid the gross premium tax on the money used to pay claims below the claims liability limit.

Under the terms of the FFPAs, Transamerica continues to have final authority to approve and deny all claims and the responsibility to defend suits resulting from denial of claims. The group insurance policies continue to define the existence and limits of the benefits, both above and below the claims liability limit. Thus Transamerica controls its ultimate profit or loss exactly as it would if the FFPAs did not exist.

This clarification is significant because it is clear that, even after the execution of the FFPAs, (1) Petitioners are insured by policies issued by Transamerica and (2) the policies continue to control the granting and the limits of the benefits. Respondents contend that Michigan law requires that Transamerica include in these policies the mandated substance abuse treatment coverage.

ARGUMENT

A. INTRODUCTION AND SUMMARY—THIS STRAIGHTFORWARD ISSUE WAS CORRECTLY DECIDED BY THE COURT OF APPEALS FOR THE SIXTH CIRCUIT BASED ON THIS COURT'S DECISION IN METROPOLITAN LIFE INSURANCE CO V MASSACHUSETTS.

Sections 3425 and 3609a(2) of the Michigan Insurance Code[1] require insurers offering health or group disability policies in Michigan to include in the policies specified coverage for substance abuse treatment. Petitioners allege they are employee benefit plans subject to ERISA who purchase health insurance policies from Transamerica Occidental Life Insurance Company. They claim Michigan cannot compel Transamerica to include the mandated coverage in Petitioners' policies because ERISA preempts state regulation of ERISA employee benefit plans. Respondents contend, and the Sixth Circuit agreed, that §§ 3425 and 3609a(2) are saved from preemption by § 514(b)(2)(A) of ERISA,[2] as laws which "regulate insurance."

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[1]

MCLA 500.3425 and 500.3609a(2); MSA 24.13425 and 24.13609a(2), as added by 1980 Public Acts of Michigan 429. These sections appear in the Appendix, *infra*, pp 1-a to 4-a.

[2]

29 USC 1144(b)(2)(A). This section is reproduced in the Appendix, infra, p 4-a.

While the instant case was pending before the Court of Appeals, this Court decided *Metropolitan Life Insurance Co* v *Massachusetts*, 471 US —; 105 S Ct 2380; 85 L Ed 2d 728 (1985). In a unanimous decision, this Court held that a Massachusetts law mandating coverage for treatment of mental illness in insurance policies was saved from preemption by § 514(b)(2)(A) as a law which regulates insurance. Thereafter, the Sixth Circuit correctly concluded that the *Metropolitan Life* decision controlled this case. In short, if Massachusetts' mandated mental illness treatment coverage was not preempted, then Michigan's mandated substance abuse treatment coverage was not preempted. The Court of Appeals' conclusion was both obvious and correct: if Petitioners elect to purchase insurance, their insurer must include the mandated substance abuse treatment coverage in the policy.

Petitioners would have this Court legislate a distinction between employee benefit plans which are insured "enough," and those which Petitioners characterize as "marginally" insured. They conclude the latter should be "treated" as though they are uninsured.[3] Nothing in the language or the legislative history of ERISA supports this fiction. Nothing in the *Metropolitan Life* decision contemplates such sophistry. Petitioners are transparently attempting to manufacture grounds for review by this Court where clearly none exist. This Court authoritatively put this issue to rest in the *Metropolitan Life* case.

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[3] Petition For Writ of Certiorari, pp 9-10.

B. MANDATED COVERAGE OF SUBSTANCE ABUSE TREATMENT ADDRESSES A SERIOUS PUBLIC HEALTH THREAT.

As in other states, substance abuse is a serious problem in Michigan. It is estimated that three-quarters of one million Michigan citizens need services for drug abuse problems. Approximately 600,000 of these are persons with problems related to alcohol use—360,000 of whom are considered alcoholics. The remaining 150,000 persons are misusing or abusing prescription and other drugs.[4]

In addition to causing incalculable human suffering, substance abuse causes staggering financial waste. Estimates put the losses due to absenteeism, health and welfare costs, property damage and accidents, and medical expenses resulting from alcohol and other drug abuse at nearly $2 billion annually in Michigan alone. Lost productivity exceeds $700 million annually in Michigan.[5]

Prior to 1982, Michigan attempted to address this problem in part by requiring insurers writing policies in Michigan to *offer* to provide coverage for inpatient and outpatient treatment of alcoholism and drug abuse, but the coverage was not required. 1974 Public Acts of Michigan 50. This is commonly referred to as a mandatory offer law.

After years of trial, the Michigan legislature concluded that "The mandatory offer laws, in effect since 1974, have not

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[4]

Michigan Comprehensive State Plan for 1980-81, Office of Substance Abuse Services of Michigan, Department of Public Health, July 1980, pp 52-62.

[5]

Economic Costs to the State of Michigan for Alcohol and Drug Abuse and Mental Illness – 1982, California Health Research Foundation, 1982, "Introduction and Summary."

significantly increased the number of persons with coverage for substance abuse care, and a more forceful approach is necessary: mandatory coverage."[6] It was anticipated that mandatory coverage would prompt persons to seek treatment at earlier stages.

> "Not only does this mean that the treatment will be less expensive than if left until acute secondary problems arise, but it means the person seeking treatment stands a better chance of avoiding the loss of income and the family strife which often accompany advanced stages of substance abuse. Effective early diagnosis and treatment of substance abuse would eliminate the need for acute care and hospitalization later, thus reducing costs to the health care system."[7]

C. PETITIONERS' CLAIM THAT THE COURT OF APPEALS MISCONSTRUED THE METROPOLITAN LIFE DECISION IS BASELESS.

Petitioners have attempted to manufacture grounds for review by this Court where in fact none exist. Their contention that the Court of Appeals misconstrued this Court's decision in *Metropolitan Life, supra,* is fanciful. On the contrary, the decision of the Sixth Circuit is entirely consistent with the spirit and the letter of the *Metropolitan Life* case.

In that case, the insurers tried to convince this Court to adopt a narrow and "rather unnatural" interpretation of the ERISA saving clause based primarily on their view that it was unwise public policy to interpret that clause as written.

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[6] "Analysis of House Bills 4196 & 4197, as enrolled," Third Analysis, February 27, 1981, House Legislative Analysis Section.

[7] *Id.*

Although Congress saved from preemption "any law of any State which regulates insurance,"[8] the insurers contended that only "traditional" state insurance regulations avoided preemption.

This Court unanimously refused to impose limitations not evidenced by the statutory language or the legislative history.

> ". . . [N]othing in § 514(b)(2)(A), or in the 'deemer clause' which modifies it, purports to distinguish between traditional and innovative insurance laws. The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind."
>
> 471 US ——; 105 S Ct at 2390; 85 L Ed 2d at 741.

Acknowledging that insured and uninsured plans are treated differently, and that nationwide employee benefit plans purchasing insurance may have to vary their benefits from jurisdiction to jurisdiction, this Court noted: "Arguments as to the wisdom of these policy choices must be directed at Congress." 471 US ——; 105 S Ct at 2393; 85 L Ed 2d at 745.

The Court of Appeals faithfully applied both the letter and spirit of the *Metropolitan Life* decision to the instant case. The Michigan statute requiring substance abuse treatment coverage, like the Massachusetts statute requiring mental health coverage, is undoubtedly a law which "regulates insurance" and, therefore, is saved from preemption. The Sixth Circuit correctly so held. Moreover, it correctly concluded that the law was no less saved from preemption because Petitioners

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[8] ERISA, § 514(b)(2)(A), 29 USC 1144(b)(2)(A).

retain some of the liability to pay benefits. Congress simply did not differentiate in § 514(b)(2)(A) between insurance laws regulating policies which are sold to fully insured plans and insurance laws regulating policies sold to plans which partially self-fund. If Petitioners find this common-sense application of the plain language of the saving clause to be unwise public policy, they can debate the wisdom of congressional choices in Congress. The Court of Appeals can hardly be faulted for following the lead of this Court and refusing to attribute to Congress an intention it nowhere indicated.

In fact, these Petitioners have at least three remedies available to them if they do not like the result in this case. First, they can prevail upon Congress to adopt their view of wise public policy and statutorily create the exception they ask this Court to manufacture. Second, they can convince the Michigan legislature to exempt them from the application of §§ 3425 and 3609a. Finally, they can simply elect to self-fund their entire program. It is not necessary (or appropriate) for this Court to adopt Petitioners' baseless interpretation of ERISA for Petitioners to avoid the logical consequence of the *Metropolitan Life* decision.

D. PETITIONERS WOULD HAVE THIS COURT LEGISLATE A DISTINCTION BETWEEN BENEFIT PLANS WHICH ARE INSURED ENOUGH, AND THOSE ADMITTEDLY INSURED PLANS, LIKE THEIRS, WHICH SUPPOSEDLY ARE NOT INSURED ENOUGH TO BE CONSIDERED "INSURED." THIS ANALYSIS IS UNSUPPORTED BY THE LANGUAGE OR LEGISLATIVE HISTORY OF ERISA AND CONTRADICTS THE WELL-ESTABLISHED RULE THAT PREEMPTION WILL NOT BE FOUND ABSENT UNMISTAKABLE CONGRESSIONAL INTENTION.

Ironically in the name of correcting the Sixth Circuit's supposed "distortion" of the difference between insured and uninsured plans, Petitioners would have this Court legislate a new distinction. Petitioners suggest that although their plans admittedly are insured, this Court should determine that they are not insured enough to be considered insured for purposes of ERISA preemption. This approach is unsupported by the language or legislative history of ERISA and contradicts the well-established rule that preemption will not be found absent unmistakable congressional intention to preempt.

To begin with, Petitioners have incorrectly framed the question in terms of whether they are insured or uninsured. The focus of an ERISA preemption inquiry, however, is not the employee benefit plan, but the state law allegedly preempted. If §§ 3425 and 3609a(2) "regulate insurance," they are saved from preemption by § 514(b)(2)(A). If they are saved from preemption, then Transamerica must comply and include the mandated coverage in its policies. Nowhere did Congress indicate that Transamerica's legal duty would vary depending upon whether it sold its insurance to fully insured plans or to plans which purportedly retain some of the liability themselves. The *Metropolitan Life* decision makes it undeniably plain that, like the Massachusetts mandated benefit law, the

Michigan mandated benefit law "regulates insurance" and so Transamerica must comply. That ends the inquiry.

Petitioners argue that their plans are separable into insured and uninsured components. In this view, they are insured only to the extent of Transamerica's obligation to pay claims above the claims liability limit. In all other respects, they argue, they are uninsured. Because Petitioners characterize the insurance as "marginal," they conclude they should be considered uninsured. Petitioners fail to support this analysis by reference to the language of § 514(b)(2)(A). Petitioners fail to support it by reference to the legislative history of ERISA. Instead, Petitioners rely upon 1982 amendments to ERISA which were expressly intended to reaffirm and strengthen the authority of the states to enforce their insurance regulations in the face of what Congress regarded as unwarranted ERISA preemption claims. Petitioners' argument is as unmeritorious after close examination as it appears at first glance.

In 1982, Congress amended the preemption language of ERISA with the express purpose of both clarifying *and strengthening* the authority of the states to enforce their insurance laws. Congress was concerned that ERISA's preemption language was being used by unscrupulous individuals to evade legitimate state insurance regulations. Typically, entrepreneurs would entice multiple small employers to participate in a trust established and administered by the entrepreneurs to provide health benefits at lower cost. These were commonly referred to as multiple employer trusts, or METs. Through incompetence, dishonesty or both, the trusts frequently became unable to pay claims and those very persons intended to be protected by ERISA, employee benefit plan participants and beneficiaries, were left with unpaid medical bills. State attempts to regulate these plans were hindered by the claim that the METs constituted ERISA plans and, therefore, the states could not enforce insurance regulations

against them due to the deemer clause, § 514(b)(2)(B). Some METs were ERISA plans. Others, the large majority, were not.[9]

Congress responded by clarifying and strengthening the authority of the states to deal with METs.[10] Congress reaffirmed its original intention that multiple employer welfare arrangements (essentially what had been known as METs) which did not qualify as employee welfare benefit plans under ERISA continued to be fully subject to applicable state regulations.

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[9]

This scenario was succinctly described by Rep. Phillip Burton in the *Congressional Record* as follows:

> "Although the Employee Retirement Income Security Act of 1974 (ERISA) was enacted to protect workers, some individuals have used ERISA as a smoke screen to conceal fraudulent activities.
>
> "These individuals approach employers, particularly small businesses, offering a cheaper alternative to traditional group health insurance coverage.
>
> "They set up trusts which they administer themselves to provide health coverage. But unlike licensed insurance carriers, they often fail to comply with the basic solvency controls which each State establishes to protect health care consumers.
>
> "When the State tries to enforce these controls, the trusts claim to be beyond the reach of State law because they are 'employee benefit plans' covered by Federal law.
>
> "By the time the U. S. Department of Labor decides if Federal law applies, the individuals who established the bogus insurance ventures have long since departed with the money and workers are left without any means of covering their unpaid medical bills."
>
> 128 Cong Rec H 9609 (daily ed. Dec. 13, 1982) (remarks of Rep. Burton in favor of § 302 of Pub Law 97-473 [96 Stat 2611] amending ERISA by adding § 514(b)(6), 29 USC 1144(b)(6)). See, also, 128 Cong Rec H 9610 (daily ed. Dec 13, 1982) (remarks of Rep. Erlenborn to the same effect).

[10]

Section 302 of P.L. 97-473 (96 Stat 2612) amending ERISA by adding § 3(40) and § 514(b)(6); 29 USC 1002(40) and 1144(b)(6).

> "The amendment reaffirms the original intent of Congress in enacting the Employee Retirement Income Security Act of 1974 (ERISA) that if a multiple employer welfare arrangement does not meet the definition of an employee welfare benefit plan under the act, then such an entity is not exempted — under the preemption provisions set forth in section 514 of ERISA — from the application of State insurance and other laws regulating such entities."
>
> 128 Cong Rec H 9610 (daily ed. Dec. 13, 1982) (remarks of Rep. Erlenborn).

In short, multiple employer welfare arrangements which are not also ERISA employee benefit plans have always been fully subject to all state laws.

But Congress also conferred *additional* authority on the states. Before the 1982 amendments, states could not apply their insurance regulations directly to METs which qualified as ERISA plans (even though a MET is essentially an insurance company) because the deemer clause prevented the states from treating employee benefit plans as insurers. By adding § 514(b)(6), Congress effectively weakened the deemer clause. It expressly permitted states to directly regulate even those METs which do qualify as ERISA employee benefit plans and, therefore, would otherwise be protected from state insurance laws by ERISA.

> "With respect to arrangements which meet the definition of ERISA plans, the amendment specifically permits State regulation in varying degrees depending on the type of arrangement and whether or not the arrangement is determined by the Department of Labor to be an ERISA covered welfare benefit plan. Thus the amendment removes any potential obstacle that might exist under current law which could hinder the ability of the States to

> regulate multiple employer welfare arrangements to assure the financial soundness and timely payment of benefits under such arrangements."
>
> 128 Cong Rec H 9610 (daily ed. Dec. 13, 1982) (remarks by Rep. Erlenborn).

What Congress did in 1982 then, was to clarify and strengthen the states' authority to regulate all multiple employer welfare arrangements. Those which do not qualify as ERISA plans have always been subject to direct state regulation. Those which do qualify as ERISA plans are nevertheless (and the deemer clause notwithstanding) subject to specified state regulation. Multiple employer welfare arrangements which are fully insured or which have been exempted by the Secretary of Labor, nevertheless must comply with state regulations providing "standards, requiring the maintenance of specified levels of reserves and specified levels of contributions," § 514(b)(6)(A)(i). All other multiple employer welfare arrangements which are ERISA plans must comply with "any law of any State which regulates insurance. . .to the extent not inconsistent with the preceding sections of this title." § 514(b)(6)(A)(ii).

In light of this background, Petitioners' reliance upon § 514(b)(6) is surprising, and plainly misplaced. That section is only relevant if state regulation of a multiple employer welfare arrangement which is also an ERISA employee welfare benefit plan is at issue. Although Petitioners claim to be ERISA employee benefit plans, they specifically do not claim

that they are multiple employer welfare arrangements.[11] Accordingly, § 514(b)(6) is entirely irrelevant to this case.

Moreover, it is undeniable that Congress specifically expressed its intention that the 1982 amendments did not address the question presented in this case, i.e., whether state-mandated benefit laws are preempted as to those insurance policies which an employee benefit plan elects to purchase.

> "This Senator might add that no provision of H.R. 5470 is intended either to overturn or endorse the decision reached by the U. S. Court of Appeals in Wadsworth, et al. against Whaland. . . ."
>
> 128 Cong Rec S 15988 (daily ed. Dec. 21, 1982) (remarks of Senator Dole).

The same sentiment had been expressed earlier in the House by Representative Burton:

> "Finally, neither sections 301 or 302 of this amendment are intended in any way either to overturn or endorse the decision of the U.S. First Circuit Court of Appeals in *Wadworth,* [sic] et al. v *Whaland* (562 F. 2d 70 1st Cir. 1977, cert denied, 435 U.S. 980 (1978), which held that

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[11]

Petition for Writ of Certiorari, p 11. The reason for this is apparent. If Petitioners were multiple employer welfare arrangements which qualify as ERISA employee welfare benefit plans, § 514(b)(6)(A)(ii) expressly authorizes the states to enforce directly against them "any law of any State which regulates insurance. . .not inconsistent with the preceding sections of this title." Therefore, Michigan could directly require Petitioners to provide the mandated substance abuse benefits, *even if Petitioners were entirely self-funded.* In the present circumstances, of course, the state is attempting no such regulation. Michigan is only requiring Transamerica to include mandated substance abuse coverage in its policies. If Petitioners elect to purchase those policies, they must necessarily purchase the substance abuse coverage as well.

> a New Hampshire insurance law regulating the content of group insurance policies sold to ERISA covered welfare plans was not preempted under section 514 of ERISA. Resolution of that issue should be dealt with in separate legislation after a full opportunity for both sides to present their views."
>
> 128 Cong Rec H 9609 (daily ed. Dec. 13, 1982) (remarks of Rep. Burton).

Finally, if Petitioners are suggesting that, although it is not directly applicable, § 514(b)(6) is indicative of some obscure congressional intention to distinguish generally between fully insured and partially insured employee benefit plans, they are twice wrong. First, given the legislative history sketched above, it is clear that Congress was addressing a specific problem which had arisen as a result of unwarranted claims of ERISA preemption. There is nothing to indicate an intention to diminish state regulation of partially insured plans. Second, this Court has repeatedly stated that preemption will not be found "in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained." *Alessi* v *Raybestos-Manhattan, Inc*, 451 US 504, 522; 101 S Ct 1895, 1905; 68 L Ed 2d 402, 416 (1981) (quoting from *Florida Lime & Avocado Growers* v *Paul*, 373 US 132, 142; 83 S Ct 1210, 1217; 10 L Ed 2d 248, 257 (1963)). Vague "suggestions" from inapplicable sections of ERISA fall substantially short of meeting this standard.

CONCLUSION

For the foregoing reasons, this Court should deny the petition for writ of certiorari.

Respectfully submitted,

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A. Section 3425 of the Michigan Insurance Code of 1956; MCLA 500.3425; MSA 24.13425, as added by 1980 Public Acts of Michigan 429.

Section 3425. (1) Required coverage. Each insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all contracts for group and individual hospital, medical, surgical expense-incurred health insurance policies other than limited classification policies.

(2) Option to decline coverage. In the case of group health insurance policies, if the premium for a group health insurance policy would be increased by 3% or more because of the provision of the coverage required under subsection (1), the master policyholder shall have the option to decline the coverage required to be provided under subsection (1). In the case of individual health insurance policies, if the total premium for all individual health insurance policies of an insurer would be increased by 3% or more because of the provision of the coverage required under subsection (1) in all of those policies, the named insured of each such policy shall have the option to decline the coverage required to be provided under subsection (1).

(3) Charges, terms, conditions. Charges, terms, and conditions for the coverage required to be provided under subsection (1) shall not be less favorable than the maximum prescribed for any other comparable service.

(4) Reduction of coverage by policy terms and conditions; deductibles and copayment. The coverage required to be provided under subsection (1) shall not be reduced by terms or conditions which apply to other items of coverage in a health insurance policy, group or individual. This subsection shall not be construed to prohibit health insurance policies

that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse.

(5) Minimum benefits. The coverage required to be provided under subsection (1) shall, at a minimum, provide for up to $1,500.00 in benefits for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(6) Definitions. As used in this section:

(a) "Health insurance policy" means a hospital, medical, or surgical expense incurred policy.

(b) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individual physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) "Limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(d) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(e) "Substance abuse" means that term as defined in section 6107 of Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

(7) Effective date. This section shall take effect January 1, 1982.

B. Section 3609a of the Michigan Insurance Code of 1956; MCLA 500.3609a; MSA 24.13609a, as added by 1980 Public Acts of Michigan 429.

Sec. 3609a. (1) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall offer to include in that policy a provision that the insurer will provide coverage for inpatient care for substance abuse to the extent agreed upon between the insured employer

or other insured organization and the insurer, to be provided in a facility approved by the department of public health for hospitalization or treatment of substance abuse. This coverage shall be subject to the provisions of sections 3406 to 3466, except section 3425.

(2) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall include in that policy a provision that the insurer will provide coverage for intermediate and outpatient care for substance abuse, to the extent required by section 3425.

(3) This section shall take effect January 1, 1982.

C. Sections 514(a), 514(b)(1), 514(b)(2) and 514(b)(6) of ERISA, 29 USC 1144(a), 1144(b)(1), 1144(b)(2) and 1144(b)(6), as amended by § 302 of P.L. 97-473 (96 Stat 2612).

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

(6)(A) Notwithstanding any other provision of this section —

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall effect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

Supreme Court, U.S.
FILED
DEC 26 1985
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-810

IN THE

Supreme Court of the United States

OCTOBER TERM 1985

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND FOOD EMPLOYERS HEALTH AND WELFARE FUND, and the BOARD OF TRUSTEES thereof; and MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS DRUG AND MERCANTILE EMPLOYEES WELFARE FUND, and the BOARD OF TRUSTEES thereof,

Petitioners,

v.

NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN; JEAN CARLSON and THOMAS PIERSON, DEPUTY COMMISSIONERS OF INSURANCE OF THE STATE OF MICHIGAN; and THE BUREAU OF INSURANCE OF THE STATE OF MICHIGAN,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF OF PETITIONERS

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No. 85-810

IN THE

Supreme Court of the United States

OCTOBER TERM 1985

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND FOOD EMPLOYERS HEALTH AND WELFARE FUND, and the BOARD OF TRUSTEES thereof; and MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS DRUG AND MERCANTILE EMPLOYEES WELFARE FUND, and the BOARD OF TRUSTEES thereof,

Petitioners,

v.

NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN; JEAN CARLSON and THOMAS PIERSON, DEPUTY COMMISSIONERS OF INSURANCE OF THE STATE OF MICHIGAN; and THE BUREAU OF INSURANCE OF THE STATE OF MICHIGAN,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF OF PETITIONERS

The Funds submit that the argument for the granting of certiorari is sufficient as presented in the Petition. This Reply Brief is prompted by the need to address a number of potentially misleading misstatements of fact and law contained in Respondents' Brief in Opposition.

A. **Respondents' Brief in Opposition Misstates the Facts and the Issue.**

After asserting in their Statement of the Case that, "[r]espondents simply do not know" the factual details underlying the Funds' contractual relationship with Transamerica Occidental (Brief in Opposition, p. 1), respondents nevertheless presume an exegesis on the history and coverage of the Funds' excess loss insurance arrangements (pp. 1-2).

Respondents' conclusory statement therein that, "[p]etitioners are insured by policies issued by Transamerica," (Brief, p. 3) is grossly misleading. The simple fact is that the Funds are not insured below the "claims liability limit," and they do not pay premiums for benefits paid below that limit. Moreover, the "claims liability limit" has never been reached in the history of the Funds' Flexible Funding Agreement with Transamerica.

The issue here, then, affecting countless employee benefit plans, is whether an uninsured, i.e., self-funded plan, otherwise concededly insulated from state regulation by §514(b) of ERISA, becomes subject to such regulation either as to the *excess* insurance coverage it purchases, or as to the plan as a whole (as respondents may (mis)read the Sixth Circuit to say).

B. **Respondents Misstate the Law of ERISA Preemption as Set Forth in ERISA Section 514 and *Metropolitan Life*.**

By means of a stilted and erroneous reading of ERISA and the Court's opinion in *Metropolitan Life Insurance Company* v *Commonwealth of Massachusetts*, 471 U.S. ____ , 105 S.Ct. 2380 (1985), the Insurance Commissioner attempts to persuade the Court that review of the Sixth Circuit's opinion is not necessary.

First, respondents argue simplistically that because Michigan Public Act 429 regulates insurance, and because laws regulating insurance are shielded from federal preemption by the "insurance saving clause," Act 429 escapes preemption and can be applied to the Funds; this *reductio* purportedly "ends the

inquiry" (pp. 9-10 of Respondents' Brief). This syllogism conveniently blinks reality. The plain rationale for Congress' inclusion of the "deemer" clause in Section 514 was to foreclose precisely such a result. The deemer clause makes it clear that it is respondents who have "incorrectly framed the question." The scope of ERISA preemption does *not* simply focus, as respondents assert (at p. 9), on the state law allegedly preempted. It could not be plainer from this Court's opinion in *Metropolitan Life, supra*, that the *deemer clause* modifies and limits the "insurance saving clause."

The deemer clause operates to focus inquiry precisely on the nature of the affected party and the nature of the insurance coverage, if any. This is plainly so from the Court's statement in *Metropolitan Life* that, "the distinction between *insured and uninsured plans*, leaving the former open to indirect regulation while the latter are not," is one "created by Congress in the 'deemer clause.' " *Metropolitan Life, supra*, 105 S. Ct. at 2393 (emphasis added). The decision below, as apparently construed by respondents, impermissibly opens the Funds, even to the extent they are *uninsured*, to the regulation of benefits that Congress and this Court have declared prohibited by ERISA's preemption and deemer provisions, thereby gravely misapplying *Metropolitan Life*.

Second, respondents' assertion (at page 8 of Brief in Opposition) that, "Congress simply did not differentiate in §514(b)(2)(A)" between indirect local regulation of fully insured plans and local regulation of marginally insured—and essentially uninsured—employee benefit plans, such as the Funds, completely misses the point, by ignoring §514(b)(2)(*B*), the deemer clause. The deemer clause, as this Court declared in *Metropolitan Life*, expresses Congress' intention that state regulation, through insurance laws, of ERISA plans is preempted at least to the extent that the plans are *uninsured*.

Third, respondents' lengthy exposition on the 1982 amendment to ERISA, Section 514(b)(6), succeeds only if their

intention was to obfuscate the issue. The Funds have not asserted and do not assert that they are "multiple employer welfare arrangements" (MET's) subject to ERISA Section 514(b)(6). That section is material, however, because it demonstrates Congress' understanding that the deemer clause preempts state insurance regulation of all ERISA plans that are not "fully insured." When Congress carved an exception to this rule, it did so expressly in Section 514(b)(6)(A)(ii). Thus, although respondents attribute to us reliance on "some obscure congressional intention to distinguish generally between fully insured and partially insured employee benefit plans" (Brief, p. 15), the 1982 enactment *expressly* distinguishes, section by section, between "fully insured" and other "multiple employer welfare arrangements."[1] Respondents do concede that the 1982 amendments were intended to extend local regulation to "multiple employer welfare arrangements" that are also ERISA plans and thereby otherwise protected from state insurance law by the deemer clause. (Respondents' Brief, p. 12). Congress clearly acknowledged the deemer clause's protection of *all but fully-insured* plans by expressly authorizing full application of local insurance law, and the inapplicability of the deemer clause, to those plans, in Section 514(b)(6)(A)(ii). Respondents simply cannot effectively obscure what a straight-forward application of statutory construction reveals: Congress' intention to shelter from state insurance regulation those employee benefit plans (other than "multiple employer welfare arrangements") which do not fund benefits completely through an insurance policy, at least to the extent they are self-funded, i.e., not insured.

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[1]Respondents gloss over this distinction in their discussion, but it is clear that the differentiation of fully insured from partially insured multiple employer welfare arrangements was central to Congress' purpose:

> "The provision generally exempts certain multiple employer welfare arrangements from the ERISA preemption provision.

Finally, the conclusion that self-funded employee welfare benefit plans carrying marginal excess loss insurance coverage are effectively *uninsured* for purposes of ERISA preemption is the *only* one which harmonizes with the Court's teaching in *Metropolitan Life*. Respondents attempt to undercut this sensible approach, and self-servingly bolster the erroneous opinion by the Sixth Circuit, by arguing in a vacuum, focusing exclusively on the insurance saving clause. (Brief at p. 10). Respondents' one-dimensional analysis merits scant consideration, since it plainly ignores the other sub-sections of Sec. 514, which, as *Metropolitan Life* demonstrates, must be read coordinately. When Section 514(a) is read in conjunction with the insurance saving clause and the deemer clause, it is apparent that where the Trustees have endeavored to protect Fund assets through the purchase of excess loss or stop loss insurance policies, the Funds are not transfigured into fully-insured benefit plans thereby subject to state insurance law. *General Electric Company* v *Gilbert*, 429 U.S. 125, 128 n. 3 (1976), *reh. den.* 429 U.S. 1079; *Dawson* v *Whaland*, 529 F. Supp. 626 nn 3, 4 (D. N.H. 1982); *General Split Corporation* v *Mitchell*, 523 F. Supp. 427, 430 (E.D. Wi. 1981); *St. Paul Electrical Workers* v *Markman*, 490 F. Supp. 931, 933 (D. Minn. 1980).

In the case of a fully insured multiple employer welfare arrangement, the provision exempts from ERISA preemption any State laws that require the maintenance of specified levels of reserves and contributions in order for such an arrangement to be considered adequately funded.

In the case of a multiple employer welfare arrangement that is not fully insured, the provision exempts from ERISA preemption any State laws that regulate insurance. Notwithstanding this provision, the secretary is authorized to determine the extent to which the ERISA preemption provision will be applied to a multiple employer welfare arrangement that is not fully insured. The Secretary's determination may be made on a case-by-case basis or a class basis."

Report of Conf. Committee, 128 Cong Rec H 10,650 (daily ed. December 21, 1982).

C. Respondents' Argument is Undercut by the Michigan Statute Which Respondents Administer.

Ironically, the treatment of the Funds as uninsured below the "claims liability limit," which respondents surprisingly characterize as "sophistry" (at p. 4 of the Brief in Opposition), is codified throughout the very law respondents are mandated to administer.

Under the Michigan Insurance Code of 1956, M.C.L.A. §500.100, *et seq.;* M.S.A. §24.1100, *et seq.*, special provisions added in a 1981 amendment, 1981 PA 189, M.C.L.A. §§500.5208(2)-(6),.5208a; M.S.A. §§24.15208(2)-(6).,15208a, apply to insurers of "noninsured benefit plans."

A "noninsured benefit plan" is defined, *inter alia*, as "*the noninsured portion of a benefit plan which has specific or aggregate excess loss insurance.*" M.C.L.A. §500.5208(7); M.S.A. §24.15208(7), as amended; see also, M.C.L.A. §500.5208a(a); M.S.A. §24.15208a(a).[2] Hence, the Michigan Legislature has adopted precisely the definition of uninsured benefit plan which the Funds suggest is minimally appropriate and which the Insurance Commissioner rejects with innuendo and without substantive reasons.

The insurer of a "noninsured benefit plan" must offer a program of specific or aggregate excess loss insurance. M.C.L.A. §500.5208(2)(b); M.S.A. §24.15208(2)(b). Significantly, an insurer's provision of excess loss coverage for a "noninsured benefit plan" qualifies as "a business activity which is *not an insurance*

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[2]This definition of "noninsured benefit plan" is consistent throughout the Michigan statutes. The Michigan Nonprofit Health Care Corporation Reform Act, which regulates provision of administrative services by medical care corporations to benefit plans, defines "noninsured benefit plan" in its Section 12b as: ". . . the portion of a health benefit plan without insurance or without coverage by a medical care corporation or hospital service corporation which has specific or aggregate excess loss insurance or coverage." M.C.L.A. §550.312b; M.S.A. §24.602(2).

carrier service" under the Code. M.C.L.A. §500.5208(4); M.S.A. §24.15208(4), as amended.[3]

Thus, it is respondents who should seek relief from the Michigan Legislature if they truly consider characterization of the Funds as "noninsured" below the claims liability limit of their excess loss insurance to be a "fiction," because this is precisely the "fiction" encoded in the insurance law of Michigan. The Michigan Insurance Code underscores the logic of considering the Funds, at the least to the extent that they are self-funded, as *uninsured* and therefore protected from application of Act 429 under the reasoning of *Metropolitan Life*.

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[3]Section 5208 of the Michigan Insurance Code of 1956 states in material part:

(1) The corporate powers of each insurer incorporated in this state shall be limited to the issuance of policies insuring persons or property or other hazards in the state of domicile and in other states from which it has received authority to transact insurance business from the insurance department of such state, and to the provision of services of the kind it performs in the normal conduct of its insurance business whether or not such services are performed in connection with an insurance contract. The prohibition of this section shall not apply to insurers organized in compliance with the insurance laws of this state, which cannot be properly authorized in other states, because the laws of such states do not permit the writing of the class or kind of insurance written by such insurers.

(2) For services provided under subsection (1) which are performed in connection with a noninsured benefit plan, the following standards shall be met:

* * *

(b) Any insurer providing services described in subsection (1) may write, and in connection with a noninsured benefit plan shall offer a program of, specific or aggregate excess loss insurance.

* * *

(4) Services provided under subsection (1) which are performed in connection with a noninsured benefit plan shall be considered a business activity which is not an insurance carrier service and shall be subject to tax as authorized by the single business tax act, Act No. 228 of the Public Acts of 1975, as amended, being sections 208.1 to 208.145 of the Michigan Compiled Laws.

* * *

(7) As used in this section, "noninsured benefit plan" or "plan" means a benefit plan without insurance or the noninsured portion of a benefit plan which has specific or aggregate excess loss insurance.

M.C.L.A. §500.5208; M.S.A. §24.15208.

D. Respondents' Argument Demonstrates the Need for Review of the Decision Below.

Respondent Insurance Commissioner's argument is compelling evidence that review of the Sixth Circuit's decision should be granted. Respondents unwittingly demonstrate precisely the danger which we argue is an inevitable and impermissible result of the Sixth Circuit's misreading of *Metropolitan Life* — that the "insurance saving" exception will be leveraged to swallow the broad preemption rule of ERISA's Section 514(a).

The Sixth Circuit's opinion is open to two readings — both untenable and in conflict with the teaching of *Metropolitan Life* (Petition for Certiorari, pp. 8-9); respondents apparently interpret the Sixth Circuit's opinion to support application of Act 429 to *the Fund as a whole*, not solely to the insurer's coverage of excess claims. This plainly erroneous result is evidenced by the startling suggestion that the *Funds* should seek an exemption from application of a mandated benefits law purportedly applicable to insurers only! (Brief in Opposition, p. 8).

That the Insurance Commissioner could so easily and wrongly conclude from the Sixth Circuit's opinion that the Funds can escape the mandated benefits of Act 429 only by becoming *completely self funded* (Brief, p. 8)—a risky alternative undertaken only by only a small number of the largest employee benefit plans—is persuasive evidence of the need for review and correction by this Court. The fact that, as we have argued, the Sixth Circuit's ruling permits the insurance saving exception to swallow the rule of broad ERISA preemption is an unanswerable argument for review.

CONCLUSION

Petitioners assert that the Petition for Writ of Certiorari should be granted. Respondents' arguments do not diminish the conclusion that the Court of Appeals has misapplied the holding in *Metropolitan Life, supra,* in a manner that merits review by this Court.

Respectfully submitted,

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